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VITAMIN A FOR CHILD SURVIVAL
CHIKWAWA DISTRICT, MALAWI
USAID CHILD SURVIVAL IX

FINAL EVALUATION

COOPERATIVE AGREEMENT # PDC-0284-A-00-1123-00

9/23/91 - 8/31/94

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INTERNATIONAL EYE FOUNDATION
VITAMIN A FOR CHILD SURVIVAL PROJECT
MALAWI

FINAL EVALUATION REPORT

AUGUST 15 - 25, 1994

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LIST OF ABBREVIATIONS

ADRA	Adventist Relief and Development Agency
A.I.D.	Agency for International Development
AIDS	Acquired Immune Deficiency Syndrome
AIDSCAP	USAID centrally-funded project contracted to Family Health International
ARI	Acute Respiratory Infections
BHR/PVC	Office of Private and Voluntary Cooperation, Bureau for Humanitarian Response (USAID)
CDD	Control of Diarrheal Diseases
CS	Child Survival
CS/VA	Child Survival/Vitamin A
DHO	District Health Officer
DIP	Detailed Implementation Plan
EEC	European Economic Community
EPI	Expanded Program on Immunization
GTZ	German Development Agency
HA	Health Assistant
HCCA	Health Center Catchment Area
HI	Health Inspector
HIS	Health Information System
HIV	Human Immunodeficiency Virus
HSA	Health Surveillance Assistant
IEC	Information, Education, and Communication
IEF	International Eye Foundation
KAP	Knowledge, Attitudes and Practices
KPC	Knowledge, Practices, and Coverage
LSV	Lower Shire Valley
MIS	Management Information System
MOH	Ministry of Health
NGO	Non-Governmental Organization (see also PVO)
ORS	Oral Rehydration Solution
ORT	Oral Rehydration Therapy
PVO	Private Voluntary Organization (see also NGO)
RHO	Regional Health Officer
SUCOMA	Sugar Company of Malawi
TA	Technical Assistance
UNICEF	United Nations Childrens Fund
USAID	United States Agency for International Development
VHC	Village Health Committee
VHV	Village Health Volunteer

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EXECUTIVE SUMMARY

The International Eye Foundation (IEF) Vitamin A for Child Survival project in Malawi was a 32-month, \$1,095,727 program which was completed on August 31, 1994. The USAID/BHR/PVC Child Survival (CS) program provided \$823,107 for the project which was implemented in the Chikwawa District of the Lower Shire Valley (LSV) in Malawi's Southern Region. The CS interventions provided include vitamin A supplementation, nutrition and AIDS education, condom distribution and promotion of oral rehydration therapy (ORT) and immunizations. A three year extension of funding has recently been granted to the project through 1997.

The area is densely populated, with high infant (136/1000) and child mortality rates (240/1000) and a high prevalence of chronic malnutrition (49% of children were <90% height for age in a recent survey). The population is only now recovering from the 1991-1992 drought and is further burdened by the integration of persons displaced by the political strife in adjacent Mozambique. HIV infection is highly prevalent, especially in trade centers and among workers at the valley's sugar plantation.

The project served an estimated 77,000 children under six and 74,000 women of child-bearing age. The major causes of death among children under five are malnutrition, pneumonia, measles, malaria, and diarrhoea. Trachoma, vitamin A deficiency and cataracts are the leading causes of blindness, affecting 1.55% of the population. AIDS is increasingly a cause of mortality in children and adults.

Since it began its work in the LSV in the early 1980's, IEF has shifted its emphasis from tertiary eye care to more community-based approaches to child health and prevention of blindness. Since 1985, IEF has helped to expand and develop community infrastructure for delivery of CS interventions in the LSV through USAID vitamin A and CS funding. The most recent project shifted and expanded project activities from 45 villages in Chikwawa and the adjacent Nsanje District to provide services to 474 villages in Chikwawa district.

Highlights among project achievements include the development of new health infrastructure in more than 470 additional villages. Despite the demands of the ambitious efforts to expand geographically, the project also achieved impressive improvements in indicators of immunization knowledge and coverage, ORT use, vitamin A supplementation coverage, and practice of exclusive breastfeeding. The project's leadership role in national awareness and policy reform regarding infant feeding practices has undoubtedly had a far-reaching impact

beyond the project area. Project activities also led to expansion of regional AIDS control programs and influenced the development of strategies for the CS project implemented by ADRA in an area south of IEF's project area. IEF's efforts to integrate vitamin A distribution in under-fives' clinics has led to nationwide use of a simple health card-based system to remind providers to provide semi-annual supplements. The project staff have also provided leadership in coordinating PVO efforts in support of the drought relief and national AIDS prevention programs.

The extension of this project for a final three years beginning in September will offer an opportunity to consolidate these impressive gains and assure sustainability. USAID and World Bank funding will provide ongoing training and salaries for the IEF Health Surveillance Assistants (HSAs) to continue their work through the Ministry of Health (MOH). The next three years must be used to work with the district's health facilities and the beneficiary communities to assure continued support and supervision of these HSAs and the network of Village Health Volunteers (VHVs) with whom they work.

I. PROJECT ACCOMPLISHMENTS AND LESSONS LEARNED

A. Project Accomplishments

A1. Project Objectives

EPI :

- 95% of the children 0-23 months of age will be completely immunized by the end of the project
- 50% of women 15-45 years of age will receive three or more doses of tetanus toxoid by the end of the project
- 85% of mothers can correctly identify the months when measles vaccination should be given to children
- 65% of women can correctly identify the protective nature of TTV vaccination

CDD :

- 75% of children 0-35 months of age will receive ORT during episodes of diarrhoea by the project
- 75% of mothers can correctly identify one or more ORT treatment strategies for diarrhoea

Nutrition :

- 60% of lactating women will exclusively breast feed their infants up to 4 months of age
- 80% of children 6 months - 6 years of age will receive vitamin A Supplementation every 6 months
- 80% of women will receive vitamin A supplementation within two months of delivery

AIDS :

- 85% of women and their husbands can correctly identify the protective nature of condoms in AIDS prevention

Primary Eye Care (PEC) :

- 80% of the village health volunteers can correctly identify five signs of a healthy eye and will identify and refer children and mothers for treatment

A2. Accomplishments by Objective

Objectives	Indicator	Baseline (4/92)	Final (7/94)
<u>EPI :</u>			
■ 95% of the children 12-23 mns of age will be completely immunized by EOP	% of children 12-23 mns of age completely vaccinated	64.9	87.5%
■ 50% of women 15-45 years of age will receive ≥ 3 doses of tetanus toxoid by EOP	% of women 15-49 years of age receiving 2 or more doses 3 or more doses	62.1% 31.1	66.0% 40.7%
■ 85% of mothers can correctly identify the months when measles vaccination should be given to children	% of mothers who can identify when measles vaccination should be given - 9 months 9-12 month	34.6% 48.6%	48.0% 65.3%
■ 65% of women can correctly identify the protective nature of TTV vaccination	% of women who can identify the protective nature of TTV	39.9%	63.7%
<u>CDD :</u>			
■ 75% of children 0-35mns of age will receive ORT during episodes of diarrhoea by EOP	% of children 0-23 months receiving ORT for diarrhea ORS for diarrhea	70.8% 45.7%	84.1% 78.5%
■ 75% of mothers can correctly identify one or more ORT treatment strategies for diarrhoea	% of mothers who can correctly identify one or more ORT Tx	62.7%	-
<u>Nutrition :</u>			
■ 60% of lactating women will exclusively breastfeed their infants up to 4 months of age	% of children exclusively breastfed at 3 months of age - may get water - no water	9.0%	11.5% 7.7%
■ 80% of children 6-71 months of age will receive vitamin A supplementation in the last 6 months	% children 12-23 mns. receiving vitamin A in the last 6 months (card documented)	16.9%	53.7%
■ 80% of women will receive vitamin A supplementation within two months of delivery	% women receiving vitamin A within 2 months postpartum - card documented only - cards & self report	----- 27.0%	38.2% 43.7%
<u>AIDS :</u>			
■ 85% of women and their husbands can correctly identify the protective nature of condoms in AIDS prevention	% women with children < 24 mns. can identify protective nature of condoms	58.3	---
<u>Primary Eye Care (PEC) :</u>			
■ 80% of village health volunteers can correctly identify five signs of a healthy eye & will identify & refer children/mothers for treatment	% of VHV's who can identify five signs of a healthy eye & refer children & mothers for Tx	---	---

A3. Constraints to Meeting Objectives

Most impressive among project achievements are those in immunization coverage (for both mothers and children), ORT treatment of children with diarrhea, vitamin A supplementation (for both children and lactating mothers) and exclusive breastfeeding. The project figure for exclusive breastfeeding among infants 0 to three months of age of 24.2% compares very favorably with the national figure of less than 5% for all children 0 to 3 months of age (Demographic and Health Surveys (DHS)).

There are the obvious cultural and social constraints to meeting objectives for knowledge and practice in such areas as infant feeding or AIDS prevention. Despite these constraints, however, the project was able to document differences, not only in the practice of exclusive breastfeeding, but also in condom use. Survey comparison of adjacent "control" (non-intervention) areas to project areas showed a significant increased use of condoms in areas reached by the project (14% compared to 8.7%, $p=.051$), suggesting that AIDS prevention activities are likely to be averting AIDS deaths in the target communities.

Differences between targets and actual achievements for these objectives are due, in large part, to the exceedingly ambitious nature of the targets. Failure to achieve the proposed targets for changes in knowledge, such as of the appropriate age for measles immunization, have obviously not been barriers to achieving the more important practice objectives. For example, though less than half (48%) of mothers can correctly identify the age for measles immunization, a much larger proportion of children 12-23 months (87.5%) are completely immunized.

The survey instrument provided for the end-of-project (EOP) had been revised since the baseline data collection. Documentation of project achievements was further constrained by the changes in survey instrument design during the project period. Project staff decided to use the updated survey to facilitate central efforts in comparison of findings among CS projects and to ensure that EOP data could also be used as the baseline for the ensuing project. The resulting lack of comparability to baseline data for this project was an obstacle to evaluation. The project might have been better advised to ask both the questions from the baseline as well as the questions from the revised survey instrument in order to have more complete data for project evaluation.

Major constraints to achievement of project objectives included a shortened duration of the project (project implementation was delayed for four months due to the no-cost extension granted to the previous project), political instability with the change to a multi-party political system and the demand for emergency response to the drought which affected the project area from late 1991 to early 1993. In addition, the project was designed to serve many new villages in which IEF had not previously worked (as IEF shifted to provide fuller coverage in one district rather than serving scattered villages in two). The need to develop a new infrastructure in over 400 new, often remote, villages in Chikwawa undoubtedly diverted

project attention from efforts to increase coverage and quality of services in the new target villages.

A4. Unintended Benefits

Unintended benefits of the project included:

- Research conducted through the project on infant feeding practice created an awareness on a national level of the problem of early supplementation, the major cause of the very high prevalence of inappropriate infant feeding practice in Malawi. This awareness, along with project staff efforts to promote reform, resulted in the elaboration of a national policy and training program to promote exclusive breastfeeding through four months of age.
- IEF CS project achievements in AIDS prevention and control allowed IEF to expand these efforts by successfully competing for additional funding from Action Aid, EEC, GTZ, AIDSCAP and UNICEF.
- ADRA reports that it drew heavily upon IEF's CS project in designing its own CS strategies in the neighboring district of Nsanje. IEF has also supported ADRA CS activities through the provision of vitamin A and training of HSAs. IEF's Peace Corps volunteer has also helped ADRA in developing its gardening and solar drying activities.
- IEF's efforts to promote distribution of vitamin A at under-fives' clinics has resulted in the use of reminder stamp for children's health cards to trigger health care providers to assess vitamin A status and provide supplements every six months. This stamp is now being used throughout the 10 districts of the Southern Region, with the likely effect of increasing the quality and coverage of vitamin A distribution activities beyond the project area.
- Regional and district-level cooperation, especially among PVOs, has increased as a result of IEF leadership in coordinating efforts of PVOs and the MOH in drought response and AIDS prevention and control.
- Publications generated from the project were another contribution of IEF and its staff to Malawi. The publications are believed to have been contributing significantly to the better understanding of the health problems of the area.

A5. Final Evaluation Survey

The results of the final evaluation survey, including a summary of key indicators, are presented in appendix 6.

B. Project Expenditures

B1. Pipeline Analysis

The pipeline analysis is attached as appendix 2.

B2. Comparison to DIP Budget

Total USAID project expenditures through August 31, 1994 (project completion date) were \$757,508. This total represents a 92% expenditure of the budget as presented in the DIP. There were over-expenditures in line items including equipment and supplies (8%, primarily due to the purchase of 20 rather than the planned 12 motorcycles and an underestimate of the cost of a vehicle) and other direct costs (49%, primarily for costs of motorcycle operation). Underspent items included headquarters personnel costs (58% underspent due to reduced billing of headquarters personnel time against the project) and headquarters travel costs (50%, due primarily to IEF staff diligence in finding reduced fare tickets and inexpensive accommodation).

Most of the budget surplus at the EOP was a result of the late project initiation date. The four-month, no-cost extension granted to the previous project reduced anticipated expenditures by reducing the duration of the project. In addition, devaluation of the local currency and a reduction of the overhead rate by 2% during the project period resulted in further reductions of planned expenditures.

B3. Handling of Finances

Handling of finances by IEF headquarters appeared, on superficial inspection (no full audit was conducted), to be appropriate. However, the IEF policy of central management of project budgets has hampered planning at the country level and has made local staff less than full participants in project implementation.

B4. Lessons Learned Regarding Project Expenditures

Chief lessons learned in the management of project expenditures include:

- Project effectiveness and capacity-building depend on empowering staff to make decisions in use of project resources to achieve the objectives. Financial control should be decentralized to the project area.
- The PVO's ability to take leadership roles in CS activities depends on having access to an appropriate budget for technical assistance (TA). While IEF effectively used TA from Wellstart and VITAP to support and promote changes in national policies for breastfeeding and vitamin A, additional TA in other areas, such as income

generation would also have been helpful. Constraints in the budget for technical assistance can prevent PVOs from having broader impact through sharing state-of-the-art solutions to emerging national problems.

C. Lessons Learned

- The decision to use MOH models for employment of HSAs, including similar training, certification and supervision by Health Assistants (HAs) in health centers, has helped to ensure their sustainability through facilitating transfer of the workers to the MOH at the end of the project.
- Investments in maintaining a good working relationship with the MOH and other collaborating institutions have been instrumental in ensuring the success of the project.
- The lack of sustained input (e.g., training, meetings, requests for action) to the Village Health Committees (VHCs) has undermined their sense of purpose, resulting in a lack of activity by these community organizations.
- Not ensuring that HSAs visit VHCs, and as a result having many HSAs directly interface with VHV, has occasionally created resentments of the VHV by VHC members, presenting a threat to their sustainability.
- The lack of timeliness in the availability of results from the baseline survey led to the selection of some inappropriately ambitious targets. As a result some staff were discouraged by the perceived lack of progress towards these targets.
- The orientation of traditional and religious leaders to the project prior to initiating project activities at the village level helped to develop a sense of community ownership of the CS program.
- The scaling-up of pilot projects to district-wide programs requires an enormous investment in the training of individuals and the development of infrastructure that cannot be completed in a short time period.

II. PROJECT SUSTAINABILITY

A. Community Participation

A1. Key Contacts in the Community

During semi-structured interviews in six communities, the final evaluation team obtained information from 10 members of VHCs, 7 other community leaders, 9 VHVs and 72 other members of the selected communities. Communities to be visited were selected from six of the nine health center catchment areas (HCCAs) within the project area. The specific villages to be visited for the interviews were selected by using the schedule for mobile clinics, choosing the village in each HCCA with a mobile clinic on the day of the interview visit or the next nearest day to the interview visit.

A2. Perceived Effectiveness of Child Survival Activities

The activities of the project are perceived by the community as very effective. Of the community members and leaders who were interviewed by the final evaluation team, 82% indicated that CS project activities were effective. Most often cited as key activities were the commodities distribution and primary eye care activities. Most community members (81%) reported that they perceived their VHV as being effective. Many also mentioned the effect of oral rehydration therapy (ORT) on the reduction of morbidity and mortality, and this recognition is reflected in the high rate of ORT use in the community.

A3. Activities for Empowerment of Communities

Several efforts to empower communities have been made. Chief mechanisms to promote community participation include the formation of Village Health Committees (VHCs) and selection of Village Health Volunteers (VHVs). Although the MOH had previously formed VHCs in many of the district villages, IEF HSAs worked with these committees to strengthen them and to help them select over 650 VHVs. IEF and other NGOs are cited by the MOH as being more successful in motivating these VHVs to continue their work, as is evidenced by the low (3 to 6%) attrition rate among IEF volunteers. Through these mechanisms to promote community participation and improve health service delivery, nearly half of community members (49%) reported that they were better able to meet their basic health needs or to sustain CS project activities as a result of the IEF CS project.

A4. Community Participation

To ensure community involvement from the outset, the project proposal was reviewed and approved by the Primary Health Care Subcommittee of the District Development Committee. Despite this work with such a representative body, only 27% of community members who were respondents in the final evaluation interviews reported that they felt their community

had participated in the design, implementation or evaluation of IEF CS activities. VHVs, with their greater contact with the project, were more likely to report a sense of community participation in project management. Several communities were visited and focus groups were conducted with mothers, volunteers, HSAs and community leaders including VHC members during the mid-term evaluation to allow them to provide input into the evaluation and provide their ideas towards the betterment of the project, although no substantial community participation was solicited during project design or preparation of the DIP. One obstacle to community participation in project management to date has been the lack of any organizational structure which represents communities within the Chikwawa district. In the future, health subcommittees of the District Development Committee (DDC) or representatives of the Area Health Committees (which have not previously been organized in Chikwawa) may be asked to assist project staff in project design, implementation and evaluation.

A5. Health Committees

Each village is expected to have a VHC. VHCs are mostly organized by the HSAs working for the MOH. Most community members and VHCs (73%) reported that the committee members are selected by the community, while others reported that they were appointed by the village headman or that the mechanism of selection was unknown. Women interviewed during under fives clinics were, however, more likely to report that the VHC members were simply "introduced" to the community, having been selected by an unknown process. All of the ten VHCs which were assessed had women members, and the average proportion of the members who were women was 40%.

One VHC reported it had met three times in the last six months, five had met twice, two had met once, while two others reported no meetings since they had been organized. It was found that VHCs are frequently bypassed by the IEF HSAs, as less than a quarter of respondents reported that the HSAs seek out members of the VHC rather than the VHV as their principal contact within each village.

A6. Issues Addressed by Health Committees

Issues addressed by the VHCs which were highlighted by their members as having been of particular importance included environmental sanitation, water supply, AIDS prevention, child spacing, and shortages of health facilities and pharmaceuticals. Three VHCs reported they had made no significant decisions or changes, though others felt their roles in promotion of latrine construction and protection of wells were particularly important.

A7. Role and Methods of Health Committees

VHCs specified their household visits and provision of health education as being most important to their work. VHC members are also trained to assist in mobile under fives'

clinics, and were observed to assist in growth monitoring and registration activities in those clinics. During home visits, VHC members may assist the Volunteer by helping to motivate families to seek appropriate services.

In some villages, however, the relationship between the VHC and the VHV has been strained, such that the Committee provides little support for the VHV in her work. IEF's tendency to bypass these committees and its provision of incentives (such as soap) for the VHV (while no compensation is provided for the VHC members) have contributed to the development of these tensions. Although there has been little solicitation of VHC input in directing the project to date, IEF plans to clarify and strengthen the rôle of the VHCs for the follow-on project.

A8. Contributive Participation

Few community members (27%) reported any contribution of cash, labor or materials for any health activities. One VHV reported that her VHC had provided labor to assist in supporting her, but three quarters of community members were reluctant to provide support of any kind for the VHV. Most (59%), however, indicated that they would be interested in having basic pharmaceuticals available for a fee at the time of service, and nearly all of these reported that the fees could be used to help support the volunteer.

A9. Reasons for the Success or Failure of Participation

A major constraint to contributive participation in Malawian communities at present lies in the political climate. In the past the Government forced people to work on "self-help" projects without any discussion or input from communities. Recent statements by the newly elected government have led Malawians to feel that no community participation or contributions in health should be expected from them, since they are "too poor" to pay for any services. Reliance on government for health care is actually increasing and communities are ill-inclined to take a larger responsibility for meeting their own health needs. A decision made by the MOH in April to begin a program of cost recovery has been shelved until the current political situation resolves itself.

B. Ability and Willingness of Counterpart institutions to Sustain Activities

B1. Persons Interviewed from Counterpart Institutions

The health center in each of the six HCCAs selected for the final evaluation survey was visited to assess IEF's relations with these counterpart institutions. These and other personnel from the MOH, other PVOs working in the Lower Shire Valley, Montfort

Hospital, and the sugar plantation (Sugar Company of Malawi (SUCOMA)) who were contacted and interviewed are listed in appendix 3.

B2. Linkage to Key Health Development Agencies

Because it was envisioned from the outset of the project that it would be sustained by the MOH, IEF's work with government and community organizations has been most critical. The MOH at every level describes IEF's linkages as appropriate and strong. These linkages have been evidenced by the cooperation in planning and collaboration in implementation of CS activities including training and evaluation. IEF has worked through the Primary Health Care Sub-Committee of the District Development Committee in obtaining local approval for the project. It also implements the project with the advice of a Program Advisory Committee which was organized at the request of IEF by the District Health Office (DHO), and is composed of representatives from the DHO, the Agriculture Development Division (ADD), the Sugar Company of Malawi (SUCOMA), and Montfort Hospital.

The IEF/Malawi has established such strong linkages with the key health development agencies largely because of the lead role played by the project staff in coordination of NGO activities with the MOH. The Country Directors have also provided technical assistance to NGOs in epidemiology and biostatistics, helping to further solidify collaborative relationships. The previous Country Director was also on the Advisory Committee for ADRA's CS activities. Joint operational research to examine the maintenance and motivation of VHVs has been undertaken by IEF in collaboration with SCF/UK.

The relationship with the Regional Health Office (RHO) has also been strengthened by IEF's ability to provide technical support. Both the RHO and the DHO have drawn upon IEF expertise in planning survey assessments and health interventions, particularly in response to the recent drought. Joint training activities have also been undertaken with the MOH, ADRA, Montfort Hospital and Trinity Hospital in Nsanje. AIDS prevention and control activities have elicited collaboration with ADRA, Montfort Hospital and SUCOMA. Agricultural activities and solar dryer development have been undertaken collaboratively with ADRA.

B3. Key Local Institutions to Sustaining Project Activities

The DHO and Montfort hospital are the major local institutions which are expected to sustain the project activities in the impact area. These two hospitals and their HCCAs will assume the responsibility for supporting and supervising the IEF HSAs. IEF has already started to work with these institution in preparation for the transfer of the HSAs and the institutions are clearly willing to assume this role. Both hospitals also expressed their desire to take part in the planning of the follow-on project, to learn more about the IEF activities, and to facilitate the smooth transition of responsibilities.

B4. Perceived Effectiveness of Child Survival
Activities by Key Local Institutions

All the child survival activities being carried out by the project are perceived useful in reducing morbidity and mortality in the target population. Some clinic staff credited the project with causing a shift in utilization of health services, reflecting a reduction of the number of cases of measles and diarrhea reaching the health center and an increase in appropriate consultations for severe illness. Some of the activities most frequently cited as effective include the research activities, surveys, training of the HSAs, facilitation of coordination among the NGOs, and community-based distribution of commodities.

B5. Capacity Building

The project was instrumental in the provision of nationwide training regarding exclusive breast feeding. District MOH staff collaborated in the training of IEF and MOH HSAs and VHVs. IEF has also assisted ADRA in the training of HSAs. Although staff at health centers have not to date been trained to supervise IEF HSAs in their community-based activities, the follow-on project will be largely dedicated to this activity. More senior management staff will need additional training in information management, community organization, adult education, and training skills.

B6. Key Local Institutional Capacity to Sustain Child Survival Activities

Financial resources will be provided through the MOH (by USAID and the World Bank) to sustain salaries, benefits and training for additional HSAs. The DHO and RHO have indicated that qualifying HSAs from IEF will be given special consideration in their applications for positions with the MOH. Motorcycles will be transferred to the MOH to facilitate field supervision, although efforts will be made to provide bicycles, rather than motorbikes, for most HSAs. Despite this "demotion" with regard to means of transportation, most (7 of 11) HSAs interviewed said they would accept a transfer to the MOH during the next project period. Although some financial and material problems are anticipated in motorcycle maintenance and training for senior staff, most activities will probably be continued successfully by the local institutions.

The largest question for sustainability relates to the VHVs. Although there are other volunteers within the MOH system, there is some risk that competing demands for HSAs time in their new roles will leave them unable to provide adequate support to sustain the VHVs in their current activities. The next project period will also be used to prepare the health centers where the HSAs will be based, ensuring that they understand the value of these VHVs.

B7. Perceived Effectiveness of Child Survival Activities by Counterpart Organizations

As noted in section B4 above, the project activities are perceived as effective by the key institutions. These interventions are generally accepted as the key national public health strategies.

B8. Transfer of Project Responsibilities

The project has received funding for a follow-on project for another three years. Negotiations have already begun with the local institutions to plan for the complete transfer of project responsibilities over the next three years. Although a detailed time schedule will be established in collaboration with the counterpart institutions in the preparation of the DIP, the transfer of HSAs will begin within the next few months. For the balance of the project period, project efforts will focus on community organization and training to ensure a smooth transition and sustainability of activities.

B9. Financial Commitments of Counterpart Institutions

The MOH had made the commitment to absorb the qualified project HSAs at the outset of the current project. Although the absorption of the HSAs has been delayed, funds have now been released and the MOH reports it is ready to begin processing of applications from IEF HSAs within the next few weeks.

B10. Reasons for Success or Failure in Keeping Their Commitments

Success of the MOH in keeping its commitment to accept the transfer of qualified HSAs may be largely ascribed to the USAID/World Bank funding in support of the salaries and training for new HSAs. Early decisions to train IEF HSAs using the MOH curriculum and to ensure their certification with the MOH were also fundamental in ensuring that they would be employable by the MOH at the end of the project. The decision to base IEF HSAs at health centers, as their MOH counterparts have been, has also helped to facilitate the transfer of IEF HSAs.

B11. Collaboration in Evaluation

Representatives from the MOH and collaborating PVOs participated in the design, implementation and analysis of mid-term and final evaluations, including national and district levels of the MOH, ADRA and Project Hope.

C. Attempts to Increase Efficiency

C1. Strategies to Increase Efficiency

In order to reduce costs and increase productivity, the project staff used many strategies. Trainings were shared and scheduled to reduce costs. Visits to the field were scheduled to minimize travel and complete several project tasks at one time. Equipment was purchased used and/or at reduced prices. Maintenance costs were minimized by taking great care to protect equipment from harsh field conditions. External evaluators for the mid-term and final evaluations were identified within the region to reduce travel expenses.

Headquarters costs were also kept to a minimum by such strategies as billing limited numbers of hours of staff time against the project and making extra efforts to reduce travel costs through low fares and sharing modest accommodations.

C2. Reasons for the Success or Failure in Increasing Efficiency

The success of these strategies is evidenced by the budget surplus which remains at the end of the project. Although a few line items were underspent due to the fact that the activity was not implemented (e.g., the unfilled position at headquarters), in general there were cost savings despite the fact that more activities were implemented than were promised in the DIP.

C3. Lessons Learned Regarding Increasing Efficiency

Some of the lessons learned in efforts to reduce costs and promote efficiency were as follows:

- Efforts to protect equipment sometimes made that support less available to mid-level management staff in Nchalo, making them less effective in their work.
- Although overall cost savings were achieved, project effectiveness suffered when staff were unaware of the levels of remaining resources which might have been expended for necessary training and technical support.

D. Cost Recovery Attempts

No cost recovery strategies have been implemented to date to offset project expenditures.

E. Household Income Generation

No household income-generating activities have been implemented by the project to date.

F. Other

F1. Sustainability-Promoting Activities

Sustainability-promoting activities carried out by the project fall into four categories, including 1) efforts to strengthen community infrastructure to sustain CS activities, 2) efforts to improve the efficiency of health service delivery systems, 3) efforts to promote community participation and demand for health services, and 4) efforts to coordinate with and strengthen the capacity of collaborating institutions.

Efforts to strengthen community infrastructure to sustain CS activities include the selection and training of VHVs and the formation and training of VHCs. Health service delivery systems have been strengthened to promote sustainability through integration of vitamin A interventions into the existing Under-Fives' Clinics, including ordering vitamin A capsules through the MOH Central medical Stores (CMS). Development of a community-based blindness prevention program in half of the villages has also helped to strengthen health service delivery.

Efforts to promote community participation and demand for health services have included health education, community organization and improvement of the supply of key child survival commodities at the village level. Efforts to coordinate with and strengthen the capacity of collaborating institutions are evident in IEF's formation of NGO/MOH coordinating bodies such as the NGO CS Collaborative Group, the Drought Relief Coordinating Unit and the Regional and District AIDS Advisory Groups. Development of a Program Advisory Committee (including four collaborating institutions) to advise project planning and implementation, and in the training provided for collaborating institutions.

F2. Implementation of Sustainability Plan

Most of the IEF sustainability strategy was satisfactorily implemented. The proposed **integration of vitamin A activities into the existing Under Fives' clinic network** is largely complete, although superficial assessments at the time of the final evaluation field interviews suggested that many children "slip through" without receiving the needed doses. Initiation of some simple quality assessment and assurance measures should rectify this finding. The **ordering and supply of capsules through the Central Government Medical Stores** is also a reality, however IEF still distributes these and other commodities to the village level.

The **community-based worker system** has been established as promised with VHVs functioning in approximately 80% (474/609) of the targeted villages. The supportive relationship which was envisaged between the VHV and the VHC is, in many cases, not a reality. However, clarification and strengthening of this relationship will be a priority for the next project period.

The integration of VHVs into the MOH health delivery system was also part of the sustainability plan. The proposed MOH support and mechanisms for continuing training of these VHVs have not been created and will have to be established during the next project, as the MOH and IEF community-based infrastructures are still largely working in parallel. Over half of the VHVs have already been trained in primary eye care (PEC), as planned in the CS sustainability strategy in order to **establish a community-based blindness prevention program in 50% of project villages.**

The **increase in community demand for CS services** which was promised in order to enhance sustainability has clearly been achieved. All seven of the health centers and mobile clinics interviewed by the final evaluation team reported an increase in the perceived demand for services which was ascribed to IEF's community-based CS programs. More than half (54%) of community members interviewed reported a perceived increase in the demand for CS services due to IEF's programs.

The sustainability strategy also specified a plan to **increase MOH capacity in monitoring and evaluation and in conducting operational research.** Some progress is evident in achieving this sustainability objective. Although MOH personnel have been involved in planning and conducting periodic evaluations of the IEF project and several health surveys have been conducted in collaboration with the MOH, an even closer relationship planned for the next project will make this technology transfer more complete.

As part of the sustainability plan, the DIP specified that certain sustainability indicators would be monitored to track progress in implementing the sustainability strategy. Data regarding one of the five proposed indicator (the attrition rate among volunteers) was recorded, analyzed and reported periodically in project documents. Data for a second indicator (the number of health centers supervising volunteers) were available, but since the total remained zero, the figures were not routinely reported. Some figures (regarding supplies of vitamin A available in health centers) were used as a basis for action (providing supplies to health centers), though no records were kept or reported to summarize the data. No data were recorded for two of the indicators, one because it was not practical (number of VHC meetings held), and the other (MOH ability to design, implement and analyze surveys) because it was not feasible to measure the indicator.

F3. Changes in Sustainability Potential

The MOH at central, regional and district levels is currently addressing the key barriers to sustainability. The fact that efforts are now underway within the MOH to improve strategies to sustain the VHCs, the VHVs, community-based distribution systems, and an HIS, suggests that there is considerable sustainability potential in project benefits. Agreements have been solidified to transfer project activities to the MOH as soon as possible within the next few months. The next three year project period will, therefore, provide an opportunity to focus on identifying areas where additional support and training may be needed in order to successfully sustain those activities which had previously been implemented by IEF.

III. EVALUATION TEAM

A1. Members of Evaluation Team

The evaluation team included two external evaluators from the Evaluation Unit of the Department of Community Health at Addis Ababa University (AAU), one representative of IEF/Bethesda, the IEF/Malawi Country Director, four senior staff members of the CS project, a representative of the MOH from the national level and one from the district level, and representatives from each of two other NGOs (ADRA and HOPE) working in CS in the Southern Region.

The specific names and titles of the evaluation team members are as follows:

<u>Name</u>	<u>Title/Position</u>
Mathews D. Alifinali	Training and Supervision Assistant/IEF
Theresa W. Banda	Senior nutritionist/MOH
Yemane Berhane	Assistant Professor, AAU
Jeffrey Brown	CS Coordinator, IEF/USA
Joe Canner	IEF Country Director, Malawi
Henderson L. Chikhosi	Project Director/IEF
Watson Chikopa	Training Coordinator/ADRA
W. C. Chimwaza	A.E.H.O./MOH
James Lusantha	Field supervisor/Project Hope
Richard Mmanga	Training and Supervision Coordinator/IEF
George Mekiseni	Information Coordinator/IEF
Sally Stansfield	Assistant Professor, AAU

A2. Authors of the Final Evaluation Report

Drs. Yemane Berhane and Sally K. Stansfield were the authors of the final evaluation report. The draft report was circulated to all evaluation team members and project staff for review

and revision. After their comments were incorporated, the report was forwarded to IEF for final preparation and submission to USAID and circulated to interested agencies within Malawi.

IV. RECOMMENDATIONS

A. Sustaining Health Service Delivery Systems

- In view of the need, over the next three years, to transfer the IEF HSAs and VHVs to the hospitals in Chikwawa District's new Health Delivery Areas (Chikwawa District Hospital and Montfort Hospital), IEF will need to involve the staff of these institutions in planning for the upcoming project and development of the DIP.
- The project should seek ways to enhance the perceived utility of outreach activities to clinical staff, such as through documenting changes in health center service utilization patterns and assisting health centers in locating and motivating defaulters from tuberculosis treatment.
- A project status report should be prepared for dissemination to both communities and collaborating institutions, describing the achievements of this project and the issues to be addressed in the new project.
- The project HIS must be reviewed in light of national, regional, and district initiatives in information systems, revising the system to retain only those components which are likely to be sustained after the end of the project.
- IEF staff should work with the new District Health Education Officer in efforts to improve DHO capacity for health education and to strengthen IEF's IEC components.

B. Community Organization and Development

- The project should proceed with its plans to involve communities in planning for the next three years. Identifying an appropriate interface with the community would be facilitated if IEF can work with a district level representative organization such as the Primary Health Care subcommittee of the DDC (District Development Committee) or with Area Health Committees.
- VHVs and VHCs should be reoriented to ensure that VHVs report to the health committee in their village (with only technical supervision provided by the HSAs) and those health committees are equipped to support and supervise their volunteers.

- The project should collaborate with selected VHCs and VHVs in pilot efforts to develop small-scale income generating activities (IGAs) which may be used to support health activities at the village level.
- With the consent of VHCs, more remote villages may be selected to assess the feasibility and effectiveness of using VHVs to recover costs of selected pharmaceuticals such as aspirin, paracetamol, and sulfadoxine/pyramethamine.

C. Strengthening the Quality of Health Services

- IEF should work to enhance sustainability by increasing the reliability of commodities supplies, including vitamin A, ORS, condoms, and tetracycline ointment at the village level.
- Support and supervision to VHVs should be strengthened, such as through quarterly meetings of clusters of VHVs, continuing education programs, and efforts to train the VHCs to provide on-site support for VHV activities.
- Team approaches to quality assurance (QA) or continuous quality improvement (CQI) should be considered as a strategy to enhance team-building, improve performance, and increase the sustainability of HSA and VHV activities.
- Fortification of sugar as a more long-term solution to endemic vitamin A deficiency deserves further exploration. IEF should work with the MOH to further explore the feasibility and expected effectiveness of sugar fortification, including through documenting the prevalence of sugar consumption among high risk children.
- Vitamin A and IGA interventions can be strengthened through promotion of the use of solar dryers, especially to preserve vitamin A-rich fruits and vegetables to enhance food security and/or generate income. Project staff would profit from an opportunity to visit other projects with IGA activities, either nationally or regionally
- IEF should proceed with its plans to extend services to SUCOMA. Home Craft Workers already in place might be trained as HSAs, who could work with volunteers who are already active there. These efforts should proceed with the full participation of the DHO to ensure continued support after the end of the project.
- Further training should be provided to HSAs, VHCs, and VHVs regarding family planning and AIDS control. Community-based distribution of condoms is clearly desirable to communities but requires further support to be effective.

D. Human Resources Management and Development

- IEF should prepare a human resources development plan as part of the DIP for the next project which addresses the needs for training (such as in supervisory skills, information systems, community organization, income generating activities, and adult education) within the MOH and Montfort Hospital, so that these institutions may better sustain IEF's community-based programs.
- In collaboration with the DHO, IEF should develop a training program for VHCs and VHVs designed to prepare VHVs to report to the VHC and VHCs to better supervise their VHVs.
- All health training provided within the district should be coordinated to ensure that IEF, Montfort Hospital and MOH staff profit from all training opportunities and are encouraged to integrate health activities.
- HSAs working for IEF should be promptly assessed and encouraged to apply for transfer to the MOH as soon as possible. Personnel cost savings from early transfer should be invested in training for DHO or other MOH staff who will be instrumental in sustaining community-based activities.
- The HAs (and/or MAs) in health centers with IEF HSAs should receive orientation and training regarding the nature of the HSAs community-based activities and in supervisory skills appropriate to better supervise those activities.

E. Project Management and Administration

- IEF needs to reduce or eliminate its role in program implementation and take a role in technical support during the next project period. This shift would be greatly facilitated by moving the project office to close proximity with the DHO in Chikwawa.
- In view of the importance of the CS project in IEF's activities in Malawi, the Country Director should spend approximately half of his time working with project staff in the field. Efforts should be made to ensure frequent consultations with senior project staff in order to improve the transparency of management practices, both in IEF/Malawi and IEF/Bethesda.
- IEF/Bethesda should decentralize financial control to Nchalo for the Malawi/CS programs. Periodic transfers of data by electronic mail might be used to ensure that both Bethesda and Nchalo have up-to-date financial information to facilitate planning.

- The DIP should be drafted in Nchalo, ensuring that each member of senior project staff takes responsibility for program planning within his own area of expertise. The long "lead time" before the DIP is due should also permit substantial involvement of community members and collaborating institutions in selecting key strategies for sustainability.
- Project equipment, including the photocopier and third computer, should be moved to the project office in Nchalo. If necessary, the budget may be adjusted to assure adequate resources to cover the anticipated increased costs of maintenance and repair in the harsher conditions in Nchalo.
- To ensure sustainability of project activities after the next three years, IEF should facilitate regular management meetings which include both the MOH and Montfort Hospital personnel.

SCOPE OF WORK
MALAWI END OF PROJECT EVALUATION
CHILD SURVIVAL FOR VITAMIN A PROJECT
CHIKWAWA DISTRICT, LOWER SHIRE VALLEY
AUGUST 15th - 25th, 1994

1. INTRODUCTION

The purpose of the End of Project (EOP) Evaluation is to review the IEF-Malawi Child Survival for Vitamin A Project in the Lower Shire Valley of Malawi. The EOP Evaluation is a requirement of the United States Agency for International Development, Bureau for Humanitarian Response/Child Survival and Health funded Cooperative Agreement No. PDC-0284-A-00-1123-00. The life of the project extends from January 1st, 1992 through August 31st, 1994.

The EOP Evaluation is estimated to require 15 days from an external evaluator. The dates of the required field visit are tentatively scheduled for August 15 - August 24th, 1994.

2. OBJECTIVES

The requirements of BHR/PVC for the final evaluation are:

- a. A narrative report (English), addressing effectiveness and project sustainability (AID guidelines provided);
- b. Results of a knowledge and practice standardized survey, covering each project intervention (will be completed in advance of evaluation);
 - i. assess the degree to which project objectives were achieved through:
 - (1) comparison of the baseline and final survey results;
 - (2) review of available H/MIS data;
- c. A final financial pipeline analysis (completed with assistance from Bethesda headquarters in advance).

Additional requirements of IEF for the final evaluation are:

- d. Assess the implementation process since the mid-term-evaluation and identify common constraints that have impeded effective implementation;

- e. Summation of other relevant IEF activities related to project development (with assistance from IEF).

Specific guidelines are provided from USAID BHR/PVC/CSH for this purpose. Additional questions for consideration will also be provided by IEF. The EOP evaluation will be made available to IEF (headquarters and country staff), USAID (Washington and Mission), and others (Ministry of Health, WHO, UNICEF). The document will serve as the required USAID EOP report.

3. ACTIVITIES

The evaluator will lead a team consisting of the IEF-Malawi staff (Country Director, Project Director, Supervisors, and Health Surveillance Assistants) and IEF-Headquarters Child Survival/Public Health Manager; an official from the Ministry of Health (to be designated); and a representative from a sister PVO (to be identified). Major tasks are:

- a. Review documentation (1 day)

Review all project related documentation (proposal, detailed implementation plan, annual report, baseline survey, mid-term evaluation and quarterly reports) This information should be reviewed in advance of arrival.

- b. Orientation (1 day)

Meet with USAID, Ministry of Health National Officials, the Southern Regional Health Officer, other pertinent agency representatives and project staff to discuss and provide input into the design of the evaluation.

- c. Preparation of interview forms (1 day)

Qualitative data will be collected through a combination of key informant interviews, focus groups, and inspection of volunteer registers. To prepare for this, *BHR/PVC Guidelines* will be used to develop a specific set of interview questions to interview:

- i. community members; ii. local leaders; iii. project volunteers; iv. project staff; and v. Ministry of Health staff (district and regional).

- d. Data Gathering (4 days)

Team members will be divided into groups each consisting of one IEF staff person paired with either a PVO or MOH representative. In a sample of project communities (6-10), teams will complete structured interviews and focus groups with: i. community members; ii. local leaders; iii. project volunteers; iv. project staff; and v. Ministry staff (district

and regional). Project staff interviews and focus groups will be limited to i., ii., and iii only; the Team Leader will conduct interviews of all above levels. The total number of interviews and focus groups will be determined in-country.

At the end of each day, findings will be summarized by team leaders and presented to the entire team for discussion. This will identify whether any changes in the questions or the interview methods, or new questions are required for the next day, and to identify response patterns.

e. Analysis (1 day)

One day is required to process major findings from all interviews and focus groups following the AID guideline headings.

f. Recommendations & Lessons Learned (1 day)

One day is required to process major recommendations and lessons learned from all interviews and focus groups following the AID guideline headings. Recommendations and lessons learned will follow the "Findings" from the previous day.

g. Debriefing (1 day)

Debriefing and presentations to the MOH (regional, central) and USAID will be conducted (and if time allows other institutions may also be included). The debriefing will consist of a review of the evaluation process, and the draft findings and recommendations.

h. Report Writing (3 days)

- i. The Team Leader will write a *first* draft report (conclusions and recommendations) for debriefing and for presentation to IEF for comments and suggestions prior to departure. Preparation of the report will be a continuous daily process of typing interview forms, interviewee lists, findings and recommendations lists. A secretary will be provided for this purpose.
- ii. The *second* draft will require additional time (1 day), incorporating staff comments from the first draft. Upon completion staff will have the opportunity to make final comments on the second draft before the final report is completed.
- iii. The *final* report in English will require 1 day. This report will be delivered to IEF Headquarters for submission to HR/PVC/CSH. Final

write-up may be completed outside Malawi. The final report must be delivered by October 15th, 1994.

4. SCHEDULE

See attached.

5. REQUIREMENTS

IEF is seeking an evaluator with proven skills in program evaluation, familiarity with USAID Child Survival program and private voluntary organizations, and preferably the country of Malawi.

6. ATTACHMENTS

AID Guidelines
IEF Additional Questions
Schedule
Report Outline

J:VEFFAD-MALSOW

Appendix 2

19-Oct-94

INTERNATIONAL EYE FOUNDATION

MALAWI VITAMIN A

9/23/91 - 8/31/94

	AID BUDGET	IEF BUDGET	Total BUDGET	AID ACTUALS	IEF ACTUALS	Total ACTUALS	AID BALANCE	IEF BALANCE	Total BALANCE
IEF:HQ									
I. PROCUREMENT									
SUPPLIES	0	3,900	3,900	789	1,815	2,604	(789)	2,085	1,296
Computer	0	900	900						
General office	0	1,500	1,500						
Prof./technical	0	1,500	1,500						
EQUIPMENT	0	1,200	1,200	850	1,000	1,850	(850)	200	(650)
Computer Upgrade	0	500	500						
Printer/VA Coord	0	700	700						
SERVICES/CONSULT	0	400	400	675	5,720	6,395	(675)	(5,320)	(5,995)
DIP Admin Support	0	400	400						
SUBTOTAL (PROC.)	0	5,500	5,500	2,314	8,535	10,849	(2,314)	(3,035)	(5,349)
II. EVALUATION	0	2,250	2,250			0	0	2,250	2,250
Admin/Report Costs	0	2,250	2,250						
SUBTOTAL (EVAL.)	0	2,250	2,250	0	0	0	0	0	0
III. INDIRECT COSTS	(See G & A Line Item on Next Pa								
IV. OTHER PROGRAM COSTS									
A. PERSONNEL - Salary	54,955	37,620	92,575	28,607	21,065	49,672	26,348	16,555	42,903
- Benefits	13,261	8,753	22,014	11,068	6,619	17,687	2,193	2,134	4,327
Public Health Program Co.									
Salary (\$35,000)	36,250	18,915	55,165						
Fringe (26%)	9,426	4,918	14,344						
Medical Director									
Salary (\$60,000)	3,950	3,950	7,900						
Director of Programs (8%)									
Salary (\$51,000)	6,430	6,430	12,860						
Fringe (26%)	1,671	1,671	3,342						
Program Assistant (8%)									
Salary (\$26,000)	3,280	3,280	6,560						
Fringe (26%)	852	852	1,704						
Administrative Officer (8%)									
Salary (\$40,000)	5,045	5,045	10,090						
Fringe (26%)	1,312	1,312	2,624						
SUBTOTAL (PERS.)	68,216	46,373	114,589						
B. TRAVEL COSTS	20,100	32,000	52,100	10,032	11,233	21,265	10,068	20,767	30,835
Public Health Program Co.									
2 RT airfare pa	9,900	9,900	19,800						
50 days per diem pa	6,600	7,500	14,100						
Professional Meetings	3,600	0	3,600						
Program Mgt. Travel									
1 RT airfare pa	0	9,900	9,900						
15 days per diem pa	0	4,700	4,700						
SUBTOTAL (Trav.)	20,100	32,000	52,100						
C. OTHER DIRECT COSTS									
Office Operations									
Telephone	0	6,000	6,000	100	2,279	2,379	(100)	3,721	3,621
Postage	0	3,600	3,600	1,101	4,640	5,741	(1,101)	(1,040)	(2,141)
A-110 Audit Fees	0	4,800	4,800	814	1,314	2,128	(814)	3,486	2,672
Equip. Main	0	400	400			0	0	400	400
Subtotal (Other)	0	14,800	14,800	2,015	8,233	10,248	(2,015)	6,567	4,552
SUBTOTAL (IV)	88,316	93,173	181,489	51,722	47,150	98,872	36,594	46,023	82,617
SUBTOTAL I,II,IV	88,316	100,923	189,239	54,036	55,685	109,721	34,280	45,238	79,518
G&A Costs 18.7%/Actuals	21,558	24,635	46,193	10,105	10,226	20,331	8,368	11,043	19,410
TOTAL HQ. COSTS	109,874	125,558	235,432	64,141	65,911	130,052	42,648	56,281	98,928

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INTERNATIONAL EYE FOUNDATION

MALAWI VITAMIN A

9/23/91 - 8/31/94

	AID BUDGET	IEF BUDGET	Total BUDGET	AID ACTUALS	IEF ACTUALS	Total ACTUALS	AID BALANCE	IEF BALANCE	Total BALANCE
FORMAT G: ESTIMATED COUNTRY PROJECT BUDGET									
I. PROCUREMENT									
A. EQUIPMENT and SUPPLIES	17,950	13,000	30,950	1,454	77,051	78,535	16,466	(64,051)	(47,585)
1. Refrigerator	0	1,500	1,500	0	699	699	0	\$01	\$01
2. Camera	200	0	200	0	177	177	200	(177)	23
3. Motorcycles (12)	7,500	7,500	7,500	0	38,610	38,610	7,500	(31,110)	(31,110)
4. Vehicle	4,000	0	4,000	0	35,650	35,650	4,000	(35,650)	(31,650)
1. Computer	0	1,500	1,500			0	0	1,500	1,500
2. Printer	0	500	500			0	0	500	500
3. Volt. Reg./UPS	0	1,200	1,200	584	335	919	(584)	\$65	251
4. Typewriter(3)	750	0	750			0	750	0	750
5. Office/House Fur.	4,000	0	4,000	900	1,580	2,480	3,100	(1,580)	1,520
6. FAX	0	800	800						
7. Main./Ins.	1,500	0	1,500						
SUPPLIES	39,375	18,875	58,250	42,431	6,824	49,255	(3,056)	12,051	8,995
1. General Office	5,250	0	4,850						
2. Paper/Printing	2,250	0	2,250						
3. Comp. Software	1,000	0	1,000						
4. Vitamin A	8,250	8,250	16,500						
5. Tetracycline	10,625	10,625	21,250						
6. Teaching Aids	3,000	0	3,000						
7. Roster Books/Bags	9,000	0	9,000						
B. SERVICES	6,800	0	6,800	12,460	8,723	21,183	(5,660)	(8,723)	(14,383)
1. Tr. Consultant	3,300	0	3,300						
2. SURVEYS - Enumer.	3,500	0	3,500						
SUBTOTAL I	64,125	31,875	96,000						
II. EVALUATIONS	11,000	11,000	22,000	18,383	0	18,383	(7,383)	11,000	3,617
Midterm/Final Eval	11,000	11,000	22,000						
SUBTOTAL II	11,000	11,000	22,000						
III. INDIRECT COSTS (See G & A line item)									
IV. OTHER PROGRAM COSTS									
A. PERSONNEL - Salary	107,250	34,250	141,500	101,866	39,338	141,204	5,384	(5,088)	296
(CD & OC) - Benefits	32,813	10,413	43,226	25,478	11,822	37,300	7,335	(1,409)	5,926
1. Country Director									
Salary (\$50,000)	60,000	18,500	78,500						
Fringe (35%)	21,000	6,475	27,475						
2. Ophthal. Consul.									
Salary (\$50,000)	47,250	15,750	63,000						
Fringe (25%)	11,813	3,938	15,751						
A. PERSONNEL - Salary	102,650	0	102,650	90,202	3,302	93,504	12,448	(3,302)	9,146
(Mal,FS) - Benefits	52,460	0	52,460	61,649	2,285	63,934	(9,189)	(2,285)	(11,474)
3. Project Director									
Salary (\$8,000)	25,200	0	25,200						
Housing (200/mo.)	7,500	0	7,500						
4. Admin. Coordinator									
Salary (\$4,000)	12,600	0	12,600						
Housing (150/mo.)	5,700	0	5,700						
5. Training Coordinator									
Salary (\$5,000)	20,750	0	20,750						
Housing (150/mo.)	7,500	0	7,500						
6. Trainers (3)									
Salary (\$3,000)	30,000	0	30,000						
Housing (100/mo.)	11,950	0	11,950						
7. Admin. Assistant									
Salary (\$2,500)	6,300	0	6,300						
Housing (50/mo.)	1,890	0	1,890						
8. Drivers(2)									
Salary (\$1,250)	7,800	0	7,800						
Housing (40/mo.)	2,920	0	2,920						
9. Peace Corps (3)									
Housing	15,000	0	15,000						
SUBTOTAL IV. A.	295,173	44,663	339,836						

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19-Oct-94

INTERNATIONAL EYE FOUNDATION

MALAWI VITAMIN A

9/23/91 - 8/31/94

	AID BUDGET	IEF BUDGET	Total BUDGET	AID ACTUALS	IEF ACTUALS	Total ACTUALS	AID BALANCE	IEF BALANCE	Total BALANCE
B. TRAVEL AND PER DIEM	110,850	26,950	137,800	100,257	15,819	116,076	10,593	11,131	21,724
a. Training Consultant									
(30 days pa @\$50)	4,800	0	4,800						
b. Local Staff Trav.	13,600	0	12,600						
c. Int. Prof. Meet.									
(1 RT Airfare)	7,500	0	7,500						
(pd @10 days pa)	3,900	0	3,900						
d. Training Sessions									
Travel	10,000	0	10,000						
Per Diems	56,000	0	56,000						
a. Country Director									
Relocate (rt air)	1,500	3,500	5,000						
Housing by GOM	0	0	0						
Security	7,500	0	7,500						
Shipping	2,500	5,000	7,500						
Storage	1,550	0	1,550						
Home Leave	2,000	1,100	3,100						
b. Ophthal Consul.									
Relocate (rt air)	0	5,000	5,000						
Housing by GOM	0	0	0						
Security	0	2,700	2,700						
Shipping	0	5,000	5,000						
Storage	0	1,550	1,550						
Home Leave	0	3,100	3,100						
Subtotal IV. B.	110,850	26,950	137,800						
C. Other Direct Costs	93,864	2,000	95,864	145,915	5,070	150,985	(52,051)	(3,070)	(55,121)
I. Vehicle/Motorcycle Operat.									
Fuel & Oils	39,250	0	30,000	43,039	812	43,851	(3,789)	(812)	(13,851)
Maint/Spares	16,750	0	11,400	58,259	1,722	59,981	(41,509)	(1,722)	(48,581)
Ins/Lic/Reg	12,750	0	9,450	21,174	1,038	22,212	(8,424)	(1,038)	(12,762)
4. Office Operations									
a. Blantyre									
Rent by GOM	0	0	0						
Telephone	4,143	0	3,900	9,697	68	9,765	(5,554)	(68)	(5,865)
Postage/Courier	1,650	0	1,650	1,033	2	1,035	617	(2)	615
Freight	0	2,000	2,000	0	0	0	0	2,000	2,000
b. Ngabu									
Rent	7,500	0	7,500	8,376	0	8,376	(876)	0	(876)
Telephone	1,950	0	1,950	1,544	0	1,544	406	0	406
Postage	660	0	660	0	0	0	660	0	660
Security	1,650	0	1,650	2,793	0	2,793	(1,143)	0	(1,143)
5. Training Sessions									
Supplies	5,161	0	5,161	0	1,428	1,428	5,161	(1,428)	3,733
Facilities	2,400	0	2,400	0	0	0	2,400	0	2,400
Subtotal IV. C.	93,864	2,000	95,864	145,915	5,070	150,985	(52,051)	(3,070)	(55,121)
SUBTOTAL IV. A.B.C.	499,887	73,613	573,500	525,367	77,636	603,003	(25,480)	(4,023)	(29,503)
SUBTOTAL	575,012	116,488	691,500	600,126	170,234	770,360	(25,114)	(53,746)	(78,860)
G&A Costs 18.7%/Actuals	138,221	25,261	163,482	93,242	17,425	110,667	44,979	7,836	52,815
TOTAL COUNTRY	713,233	141,749	854,982	693,367	187,659	881,026	19,866	(45,910)	(26,044)
TOTAL COSTS	823,107	267,307	1,090,414	757,508	253,570	1,011,078	65,599	13,737	79,336

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Appendix 3

PRINCIPAL CONTACTS

IEF

Henry Kalavina	Health surveillance Assistant Supervisor
Golden Makata	Accounting-Administration
Mathews D. Alifinali	Training and Supervision Assistant
M. Kuthewela	Health Surveillance Assistant
J. Kapenga	Health Surveillance Assistant
J. Mpende	Health Surveillance Assistant
Mr. Helvrick Lockie	Health Surveillance Assistant
E. Gombeza	Health Surveillance Assistant
Gombeza Maperera	Health Surveillance Assistant
Jim Chiosa	Health Surveillance Assistant
B. Kabualo	Health Surveillance Assistant
L. Cholokhoto	Health Surveillance Assistant
J. Chisenga	Health Surveillance Assistant
J. Naraya	Health Surveillance Assistant
M. Thoyo	Health Surveillance Assistant
Chris Nsona	Health Surveillance Assistant
F. Kupheka	Health Surveillance Assistant
Onita Misonswe	Village Health Volunteer
Ms. Dorothy Alumewda	Village Health Volunteer
Ms. Rebecca John	Village Health Volunteer
Ms. Mary Chipaliwali	Village Health Volunteer
Ms. Eunice Macfield	Village Health Volunteer
Noinenenji Tinnerson	Village Health Volunteer
Matialiya Nsabwe	Village Health Volunteer
Patrick Magauizo	Village Health Volunteer
Ms. Hilda Stephen	Village Health Volunteer
Ms. Lucy Belief	Village Health Volunteer
Ms. Mary Chigudu	Village Health Volunteer

Montfort Hospital

Sr. M.B. Mkoka	Matron
Dr. Van Aalen	Medical Officer
Dr. P.C. Masache	Senior Medical Officer
A.F. Salamu	Administrator

SUCOMA Medical Office

Mr. Rowland Gondwe	Medical Technician
Mr. Bernard M. Kachale	Estate Health Officer
Mr. A.J. Kapeta	Environmental Health Inspector
Ms. Ellen F. Kebbie	Estate Matron

MOH

Dr. Henk Bekedam	Regional Health Officer
Mr. E.P. Iumula	Regional Health Inspector
Mrs Violet Kamfose	Family Health Officer, MOH, Blantyre
Ms. Lucretia Kuchande	PHC Program Assistant, CPAR
Mr. Mabwera	Senior Medical Assistant, Maperera HC
Mr. Mtambalika	Health Assistant/Maperera HC
Dr. D.S. Nyangulu	Controller, Preventive Health Svcs.
Ms. Lilian Selenje	Project Officer, UNICEF
Dr. H.M.J. Shaba	National PHC Coordinator
Dr. E.F. Venemans	Chikwawa District Health Officer
Mr. Mabwera	Senior Medical Assistant, Maperera
Mr. Mtambalika	Health Assistant, Maperera
Mr. Munthali	Health Assistant, Ndakwera
Mrs. Mero	Dolo Health Center
Mrs. Misasi	Nurse, Ndakwera HC
Mr. Gobede	MCH Coordinator, Chikwawa

PVOs

Dr. Joyce Cook	CS Project Director, ADRA
Mr. P.S.R. Kantunda	PHC Coordinator, CHAM

USAID

Mr. Chris McDermott	Chief, Health and Population
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Appendix 4

**MALAWI END OF PROJECT EVALUATION OF IEF CHILD SURVIVAL PROJECT
CHIKWAWA DISTRICT, LOWER SHIRE VALLEY
AUGUST 15th - 25th, 1994**

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
7	8	9	10	11	12	13
						Trip to Blantyre
14	15	16	17	18	19	20
Discussion with IEF field director	Meeting - RHO - staff	Interview form development Meetings - ADRA - DHO	Field Interview	Field Interview	Meetings	Data Analysis
21	22	23	24	25	26	27
Draft writing	Discussion with project staff	Debriefing				

Appendix 5

Documents Reviewed

IEF Malawi Vitamin A for Child Survival Project. Country Proposal. December 1990.

IEF Malawi Vitamin A Project. Final Evaluation Report. January 1992.

IEF Malawi Vitamin A for Child Survival. Baseline Survey Results. August 1992.

IEF Malawi Vitamin A for Child Survival. Detailed Implementation Plan. June 1992.

IEF Malawi Vitamin A for Child Survival Project. Mid-term Evaluation Report. December 1993.

IEF Malawi Vitamin A for Child Survival. Quarterly Progress Report # 7 . July - September 1993.

IEF Malawi Vitamin A For Child Survival. Project Proposal. January 1994.

Appendix 6

**VITAMIN A FOR CHILD SURVIVAL
CHIKWAWA DISTRICT, MALAWI
USAID CHILD SURVIVAL IX**

FINAL EVALUATION SURVEY

COOPERATIVE AGREEMENT # PDC-0284-A-00-1123-00

Prepared by:

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September 1994

LIST OF ABBREVIATIONS

A.I.D.	Agency for International Development
AIDS	Acquired Immune Deficiency Syndrome
ARI	Acute Respiratory Infections
BHR/PVC	Office of Private and Voluntary Cooperation, Bureau for Humanitarian Response (USAID)
CDD	Control of Diarrheal Diseases
CI	Confidence Interval
CS	Child Survival
CSSP	Child Survival Support Project (JHU)
CS/VA	Child Survival/Vitamin A
DHS	Demographic and Health Survey
DIP	Detailed Implementation Plan
EA	Enumeration Area
EPI	Expanded Program on Immunization
HIS	Health Information System
HIV	Human Immunodeficiency Virus
HSA	Health Surveillance Assistant
IEC	Information, Education, and Communication
IEF	International Eye Foundation
JHU	Johns Hopkins University
KPC	Knowledge, Practices, and Coverage
LSV	Lower Shire Valley
MOH	Ministry of Health
NGO	Non-Governmental Organization (see also PVO)
OR	Odds Ratio
OPV	Polio Vaccine
ORS	Oral Rehydration Solution
ORT	Oral Rehydration Therapy
PHC	Primary Health Care
PVO	Private Voluntary Organization (see also NGO)
SUCOMA	Sugar Company of Malawi
TBA	Traditional Birth Attendant
TTV	Tetanus Toxoid Vaccine
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VHC	Village Health Committee
VHV	Village Health Volunteer
WHO	World Health Organization

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APPENDICES

Summary of Results of Key Indicators
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I. EXECUTIVE SUMMARY

A Coverage, Knowledge and Practices (KPC) survey was conducted in 60 rural villages in Chikwawa District in the Lower Shire Valley of Malawi in July 1994 for use in the final evaluation of the second phase of the International Eye Foundation's (IEF's) Vitamin A for Child Survival Project. Results will aid with the design of new activities and modification of some continuing activities.

The objectives of the survey were to obtain information regarding the knowledge, attitudes and practices of mothers of children under two years of age concerning child survival activities, and to identify health care factors most commonly involved at the household level with childhood illnesses. The objectives of the survey were accomplished within three weeks.

The Vitamin A for Child Survival Project is being implemented by the International Eye Foundation, under a grant from the A.I.D. Bureau for Humanitarian Response, Office of Private and Voluntary Cooperation (BHR/PVC). The project is implementing Child Survival activities in over 470 communities. The project implementation period for the phase in question began September 1, 1991 and finished August 31, 1994. The project is currently in its final phase of implementation and phase-over to the Malawian Ministry of Health (MOH). It is scheduled to end August 31, 1997.

The survey was designed by IEF Headquarters and its Malawi field office. External, paid interviewers were trained in WHO cluster sample survey methodology. Three teams of ten interviewers and three supervisors conducted this survey. It consisted of sixty clusters of ten cohort household survey interviews of mothers with children less than two years off age. Thirty clusters were randomly selected from program villages and thirty additional clusters were randomly chosen from adjacent areas not currently served by the project but were targeted for service under the new project extension. The use of this methodology yielded information with which to measure the changes in health practice and knowledge indices over the past two years in project areas, provided a comparison of results between project areas and non-intervened areas, and finally, produced baseline information for the new communities to be served under the project extension.

Major findings include:

- Children's immunization coverage was high with 87.5% of children 12-23 months of age being completely immunized.
- Mother's Tetanus Toxoid Vaccine (TTV) coverage, while improved, was still low, with only 40.7% of mothers having received three or more doses of TTV.
- Treatment of diarrhea with ORT was extremely high with 84.1% of mothers reporting treating their child's most recent episode of diarrhea with ORT. Over 78% of mothers treated their child's diarrhea with ORS, a significant improvement.

- While the rate of exclusive breastfeeding for children under four months of age is low at 24.2%, this is 36% higher than in adjacent, non-intervened areas. In addition, exclusive breastfeeding of three month olds, not considering water as a supplement, increased to 11.5%, a 27% improvement from the baseline figure of 9%.
- Vitamin A supplementation of children 6-71 months of age had tripled to over 53% coverage.
- While vitamin A supplementation of postpartum women increased moderately to 38%, the majority of these women still are not receiving vitamin A.
- Knowledge levels of mothers regarding transmission of HIV is high yet condom usage is low. Nevertheless, condom usage is significantly higher in program areas as compared to control areas.
- Usage of modern family planning methods is very low (18.9% of non-pregnant women), yet unmet demand is very high. Sixty-eight percent of all women said they would like to be using a modern family planning method.

II. INTRODUCTION

A. BACKGROUND

The project works in Chikwawa District in the Southern Region of Malawi. Chikwawa District was originally chosen because of its dense population, high rates of infant and child mortality and high rate of chronic malnutrition. This district has been severely impacted by the presence of over 100,000 Mozambican refugees, many of whom lived in Malawian villages and utilized already overburdened health resources.

Malawi has some of the highest child mortality rates in the world. The Malawi 1992 Demographic and Health Survey measured an infant mortality rate (IMR) of 136 per 1000 and an under five's mortality rate of 240 per 1000. This means that nearly one-quarter of all children born in Malawi do not reach their fifth birthday. Chikwawa District rates closely mirror the national rates.

In Chikwawa District, major causes of child morbidity include malaria and diarrheal diseases. The leading causes of child mortality are malnutrition, AIDS-related complaints, pneumonia, measles, malaria and diarrhea diseases, all of which are devastating when accompanied with vitamin A deficiency. The maternal mortality rate is approximately 450 per 100,000 according to a 1990 Malawi MOH population-based study in the country's Southern Region.

Vitamin A deficiency is a significant public health problem in Malawi. A 1983 population-based survey of children conducted by the MOH, Johns Hopkins University and the IEF in the Lower Shire Valley revealed a prevalence of active xerophthalmia of 3.9%. Night

blindness prevalence was five times in excess of the World Health Organization's (WHO) criteria for a problem of public health significance while corneal scars were 10 times above WHO diagnostic criteria. Similarly, in 1992, the current project analyzed serum retinol levels of 50 children admitted to the Southern Region's Central Hospital for malaria. All 50 children had abnormally low serum retinol levels.

Malnutrition is a serious health problem. Recent nutritional assessments have shown a 3.5% prevalence of moderate to severe wasting (<80% weight for height) and a 49% prevalence of moderate to severe stunting (<90% of height for age), one of the highest rates of chronic malnutrition in the world. Only 3% of mothers exclusively breastfeed their children during the first four months of life (Malawi Demographic and Health Survey, 1992).

Chikwawa District vaccination coverage is significantly lower than national levels. Baseline data show only 65% of children 12-24 months of age are fully immunized and 65% were immunized against measles compared with respective national figures of 82% and 86%. District Tetanus Toxoid Vaccination (TTV) coverage is abysmally low, with only 31% of mothers having received at least two doses of TTV compared with the national average of 86%.

Nationally, ORT use is low with only 56% of mothers using either ORS packets or home solution to treat their child's diarrhea. Project baseline data is slightly more positive, indicating that 46% of mothers provide their children with ORS while 24% utilize some form of sugar-salt solution. Over 29% of mothers attempt to treat their child's diarrhea with something other than ORT. Furthermore, children that received supplemental foods during the first four months of birth experienced seven times more diarrhea than those children who received only breastmilk. (Project Baseline Report, 1992).

While most women receive some level of antenatal care, most of it is provided by traditional birth attendants (TBAs), many of whom are untrained. Only 51% of rural births are attended by a medically-trained person (Project Baseline Report, 1992).

Malawi has one of the fastest growing and largest AIDS problems in the world. The Johns Hopkins University/MOH AIDS Project has estimated an HIV seroprevalence among antenatal women (15-49 years of age) of 31%, based on antenatal women presenting at the Southern Region's Central Hospital. Seropositivity of a similar rural population is estimated at 12%. HIV transmission is almost exclusively limited to heterosexual sexual intercourse, yet less than 7% of women interviewed reported using a condom in the past year.

Rapid population growth exacerbates all of the above health problems. While the total fertility rate is over 7.5, modern contraceptive prevalence is only 7% (Malawi Demographic and Health Survey, 1992). The population growth rate is estimated to be 4.3% (UNICEF, 1993).

The project goal is to decrease infant and child morbidity and mortality in Chikwawa District in Malawi's Lower Shire Valley through vitamin A supplementation, improved nutrition, infection control, improved maternal care, increased family planning and HIV/AIDS prevention.

Principal interventions and their associated beneficiary populations are as follows: 1) vitamin A supplementation of children under 6 years of age and postpartum women, 2) diarrheal disease management of children under 24 months of age, 3) nutrition education for mothers with children under two years of age, emphasizing exclusive breastfeeding and timely supplementation with appropriate weaning foods, 4) support of MOH immunization activities focusing on children under 12 months of age and women of child-bearing age, 5) training of MOH personnel, including health surveillance assistants (HSAs), health assistants, health inspectors, nurses, medical assistants and clinical officers in the treatment of vitamin A deficiency and control of diarrheal diseases (CDD), 6) provision of HIV/AIDS education and distribution of condoms, and 7) training and support of traditional healers in primary eye care and AIDS prevention.

B. OBJECTIVES OF THE SURVEY

The objectives of the survey were to provide the IEF with information about the following issues:

- Knowledge of mothers of children under two years of age about: major threats to infant, maternal and child health; ways to prevent immunizable diseases; proper treatment of diarrheal diseases (ORT); signs, symptoms and treatment of acute respiratory infections; appropriate nutrition/weaning practices; information about vitamin A intake and its effect on the prevention of infectious diseases and HIV/AIDS prevention.
- Actual practices of mothers with regard to the interventions mentioned above and target groups for health education action messages for future projects.
- For children aged 12-23 months: the coverage rates of BCG, DPT3, OPV3, measles vaccines and drop out rates between series antigens.
- For children aged 12-23 months: the coverage rates of vitamin A capsule distribution in the last year.
- For mothers, the coverage rates of TTV and vitamin A capsule distribution (pregnant mothers).
- Estimate of unmet need for modern contraceptives among mothers.

The data collected will assist the project with planning, management and assessment of project activities targeted towards changing behaviors at the household level.

III. METHODOLOGY

A. SAMPLING PROCEDURES

The most recent census information available is for 1987. Census data is collected by enumeration area (EA) which are designed to be approximately equal in population. Thus, some EAs include several villages and some villages span two EAs. The village was used as the sampling unit (total villages = 686). Village populations were listed in EA number order to form a sample frame.

Next, the district was divided into two areas. The first area includes all health center catchment areas which IEF has been working in for at least one year (Makhwira, Dolo, Chipwaila, Nsua Island, Ng'abu, Ndakwera, and Maperera). The second area includes all remaining areas, including health center catchment areas that IEF has recently begun to work in (Chikwawa, Kakoma), catchment areas which IEF plans to begin work in during the next project (Chapananga, Gaga) and areas covered by other institutions (Nchalo area covered by Montfort Hospital, SUCOMA). Census maps were used to identify which EAs fall in the various areas.

In each of the two areas, thirty villages were chosen at random using the cumulative populations from the sample frame.

In each village a point in the center of the village was chosen and a pen was spun, the point determining the direction in which the survey team located the nearest house. The team then counted the number of houses to the boundary of the village and chose a house at random to begin with. The team then proceeded to survey each household, in each case choosing the nearest household. At each household, a short demographic survey was completed and if the household contained any children under two years (24 months) of age the complete interview was administered with respect to the youngest child in the household. A calendar of events going back to 1945 was prepared to assist interviewers in determining the ages of mothers. The survey team completed their work in the village when ten questionnaires had been completed.

The sample reflects mothers with one or more (live) children under 24 months of age. Mothers who have no children in this age group, although they may have given birth in the past two years, were not included for interview. There were no refusals; all villages were notified a day in advance to ensure cooperation.

B. SURVEY FORM

The survey form (Appendix) was a modification of the JHU PVO-CSSP standard survey questionnaire. A few questions were added concerning AIDS and some questions were rearranged to suit the local situation. In addition a demographic survey form was designed for all households, to ascertain information on mortality and fertility. The forms were translated into Chichewa (Malawi national language), re-translated into English, modified and pre-tested. Ten enumerators, who had worked with IEF on several surveys in the past, were hired and

trained over a five day period with time set aside for practice. After each practice session the team reviewed problems and appropriate modifications were made to the survey questionnaire.

C. TIME FRAME & SURVEY TEAMS

The survey was started on July 18, 1994 and was completed on 1st August, 1994, a total of thirteen working days. The enumerators were divided into three teams. One team was based in Ng'abu, one team was based in Chikwawa and one team was based in Makhwira. The team leaders were Mr. Mekiseni (Information Coordinator), Mr. Alifinali and Mr. Kalavina (HSA Supervisors).

D. DATA ENTRY, ANALYSIS & REPORTING

Data were entered by IEF staff in Blantyre into a personal computer using EPI-INFO software. EPI-INFO was also used to perform checks on the data and basic tabulations. Data was cleaned and analyzed by the Country Director, Mr. Canner.

IV. RESULTS AND DISCUSSION

A. DEMOGRAPHIC INFORMATION

The age of the mothers interviewed is given in Table 1. As can be seen in the table the average age of mothers was less than thirty years.

Table 1
Age of Mothers Interviewed

<u>Age of Mother</u>	<u>IEF Areas</u>	<u>Non-IEF Areas</u>
	<u>No. (%)</u>	<u>No. (%)</u>
<20 years	23 (7.7)	29 (9.7)
20-29 years	165 (55.0)	139 (46.3)
30-39 years	85 (28.3)	87 (29.0)
40+ years	23 (7.7)	44 (14.7)
Unknown	4 (1.3)	1 (0.3)

	300 (100)	300 (100)

Few mothers were literate as can be seen in Table 2, consistent with other surveys in Chikwawa District. It is encouraging to see that the youngest age groups have the greatest proportion of literate mothers.

Table 2
Literacy of Mothers by Age

<u>Age of Mother</u>	<u>IEF Areas</u>	<u>Non-IEF Areas</u>
	<u>No. (%)</u>	<u>No. (%)</u>
<20 years	7 (30.4)	10 (34.4)
20-29 years	31 (18.8)	45 (32.6)
30-39 years	12 (14.1)	19 (21.8)
40+ years	1 (4.3)	7 (15.9)
Unknown	0 (0.0)	0 (0.0)

	51 (17.0)	81 (27.0)

Nearly two-thirds of mothers (60.3.%) had a source of income, however small. The most common sources of income by far was harvesting and/or selling farm products. Only 7.7% had what could be considered a regular source of income: household servant, shopkeeper, etc.

Conclusion

Only 17% of mothers are literate. The Project should continue to utilize adult learning methodologies such as demonstrations, role plays, pictorial presentations and group discussions.

Many mothers are engaged in some sort of work outside of the household, whether it be in the fields or in the market. As a result project activities should take place with due consideration of the mother's large workload and busy schedule.

B. ACCESS TO/UTILIZATION OF HEALTH CARE FOR MOTHERS & CHILDREN

Road to Health Cards

Road to Health cards are issued by the Ministry of Health and all other health providers to children upon birth. If a Road to Health card is lost or temporarily missing an additional card will be issued. It is suggested that women keep these cards until the child is at least five years of age. Thus, a Road to Health card indicates that there has been the most basic interaction between the health system and the child. The absence of a card does not assume that there has been no interaction; the presence of a card does indicate that there has been interaction. Overall, 6.0% of the children had no Road to Health card. There was no difference by IEF area.

All analyses based upon collection of information from Road to Health cards (immunization, vitamin A supplementation, growth monitoring) will represent children with these cards. Children without Road to Health cards are assumed to not be fully immunized and not to have received vitamin A in the past 6 months.

Table 3
Does Mother have Road to Health Card for Child

	IEF <u>no. (%)</u>	non-IEF <u>no. (%)</u>	
Yes	282 (94.0)	276 (92.0)	
No	13 (4.3)	11 (3.7)	p=0.15
Lost	5 (1.7)	13 (4.3)	
	300 (100)	300 (100)	

Maternal Health Cards

The mother, as well, is given one or more cards for recording various services received. When she is pregnant and visits an ante-natal clinic she receives an ante-natal card which is only used during that pregnancy. In addition she may also receive a TTV card when she receives her first TTV so that future vaccinations can be recorded. Fifty-six percent of women had an antenatal card from their pregnancy with the index child (Table 4). That 34% of women have lost their cards is not surprising since once the pregnancy is over, the card is considered no longer needed.

By contrast as can be seen in Table 5, 73.0% of women had a TTV card and only 10.0% had lost them, indicating the need to retain the card for a longer period of time.

Table 4
Does Mother have Antenatal Card

	IEF <u>no. (%)</u>	non-IEF <u>no. (%)</u>	
Yes	169 (56.3)	142 (47.3)	p=0.03
No	29 (9.7)	47 (15.7)	
Lost	102 (34.0)	111 (37.0)	
	<hr/> 300 (100)	<hr/> 300 (100)	

Table 5
Does Mother have TTV Card

	IEF <u>no. (%)</u>	non-IEF <u>no. (%)</u>	
Yes	219 (73.0)	232 (77.3)	p=0.17
No	30 (10.0)	33 (11.0)	
Lost	51 (17.0)	35 (11.7)	
	<hr/> 300 (100)	<hr/> 300 (100)	

Discussion

Access to care for children under age two in Chikwawa District is very good as evidenced by the large proportion of mothers who have Road to Health Cards for their children. This proportion is unchanged from the baseline survey. Access to care for the mothers themselves is less complete as evidenced by the proportions of women with antenatal care cards and TTV cards. Half of the women had antenatal care cards and almost three-quarters had TTV cards. The latter figure is up from 56% in the baseline survey. Antenatal cards were not examined in the baseline survey.

If we include a lost card as evidence of access to care, the figure rises to 90.3% for antenatal care cards and 90.0% for TTV cards. These figures suggest good access to care for mothers as well. Nevertheless, MOH and project staff need to remind mothers as to the importance of guarding their antenatal and TTV cards.

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C. KNOWLEDGE & PRACTICE REGARDING VITAMIN A SUPPLEMENTATION

Vitamin A Supplementation of Children

Vitamin A supplementation of children under 6 years of age is generally recorded on the Road to Health card. Among children in the survey aged 12-23 months, 53.7% in the IEF area and 44.7% in the non-IEF area ($p=0.15$) had received a vitamin A capsule in the last six months. This is a considerable improvement over baseline, when the coverage in this age group was 18.2%. The small difference between the two areas probably reflects increased awareness on the part of the MOH regarding the importance of vitamin A supplementation. It is also possible that the IEF area rate is underestimated since vitamin A is distributed in the village and may not always be recorded on the Under-five card.

Vitamin A Supplementation of Post-Natal Mothers

The Road to Health card is often used to record vitamin A supplementation of post-natal mothers. However, it is sometimes recorded elsewhere or not at all. Of all mothers in the survey, 38.3% in the IEF area and 26.8% in the non-IEF area ($p=0.004$) were documented as having received a vitamin A capsule within two months of delivery. Approximately six percent reported having received a capsule but with no documentation and another 6% received a capsule after the recommended two month limit. This represents only a small improvement over baseline (27% of mothers of children 12-23 months of age) indicating the need for increased awareness of the benefit of supplementing post-natal mothers.

Knowledge & Attitudes Regarding Vitamin A Supplementation

Just over one third of women (30.0%) could not state any benefits of vitamin A as compared to 37.3% for women in the non-IEF area ($p=0.06$). There were no consistent relationships between either mother's age or literacy and lack of knowledge of vitamin A.

Of the remaining two-thirds who stated at least one benefit of vitamin A, 86.2% included one of the recognized benefits (blindness, diarrhea, ARI) versus 78.7% for the non-IEF area ($p=0.05$). There was a slight decline in this figure with increasing age of the mother, but no discernable trend by literacy.

Discussion

Vitamin A supplementation of children has improved substantially since baseline in both IEF and non-IEF areas. This suggests that IEF activities have indirectly influenced non-IEF areas. Yet the coverage noted by this survey is much lower than recorded by internal IEF family register audits which suggest that the coverage rate may actually be as high as 80-85%. Reasons for this discrepancy could include any of the following:

- Failure of HSAs and VHVs to record vitamin A supplied in the village on the Road to Health Cards so that the full extent of vitamin A coverage can be documented.
- Failure of VHVs to record all eligible children in their family registers.

HSAs and VHVs need to be encouraged to record vitamin A supplied in the village on the Road to Health Cards and to ensure that their registers are regularly updated to record all children in a village.

Vitamin A supplementation of postpartum women also needs attention. Special efforts need to be undertaken to improve this situation, including:

- Increasing awareness of post-partum women and maternity nurses of the need for supplementation. Also increase awareness of primary health care (PHC) providers regarding possibility of supplementing mothers at first immunization visit.
- Education of TBAs regarding vitamin A supplementation and providing TBAs with vitamin A capsules.
- Increased education of VHVs and HSAs to provide vitamin A in the villages during household visits.
- Increased consensus among health care workers as to where to note mother's vitamin A supplementation.

While knowledge of the benefits of vitamin A is quite widespread, there is still a substantial proportion of women who cannot correctly identify a benefit of vitamin A supplementation. Efforts to improve this knowledge may be beneficial in improving vitamin A coverage.

D. KNOWLEDGE & PRACTICE OF WEANING

Knowledge & Attitude Regarding 1st Introduction of Supplemental Foods

Over one half of the mothers (53.3%) reported that weaning foods should be first introduced between four and six months of life; 31.7% said it should be before four months of life; 12.7% said after six months. Only 2.3% of mothers did not know when weaning foods should be introduced. There were not differences by area, mother's age or literacy. This is a considerable improvement in knowledge over baseline, when 61.5% of mothers said supplementation should begin before four months of life.

Practice Regarding 1st Introduction of Supplemental Foods

While only 24.2% of infants under four months of age are being exclusively breastfed, this is figure is 36% higher than that of the non-IEF area. Considering only children three months of

age, 7.7% of children receive only breast milk. If one does not consider water as a supplement then 11.5% are being exclusively breastfed. These numbers, while not very encouraging, represent a 28% improvement over baseline, when only nine percent of mothers of infants age three months said they were not giving their children "food" (water not excluded).

Clearly, practice regarding exclusive breastfeeding is lagging behind knowledge. Of those women with children under four months of age who said supplementation should start at four months or later, the 69% had already begun supplementing with either water or food.

Not surprisingly, given the high prevalence of early supplementation, there is little problem with late introduction of solids. Among all children aged 5-8 months 98.2% are being fed some solid foods.

Giving support to the claim that early supplementation is harmful to infants, 14.9% of children under the age of four months who received supplemental food in both IEF and non-IEF areas had diarrhea in the last two weeks, versus 0.0% of children who were exclusively breastfed or given only water. This may suggest that the cause of diarrhea is the child's inability to process food, rather than pathogens in the water. This is confirmed by the observation that, among all children under four months of age in all areas, 12.3% of those given water had diarrhea in the last two weeks, versus 10.9% of those not given water ($p=0.80$).

Table 6
Early Supplementation by Age

Age	% given food and/ or water	% given at least food
<1 mo	54.5	9.1
1	40.0	20.0
2	84.2	73.7
3	92.3	88.5
0-3	75.8	60.6

Practice Regarding Cessation of Breast Feeding

Of all children in the survey 20-23 months of age 76.5% were still being breastfed as compared to 61.2% in the non-IEF area ($p=0.15$).

Abrupt Discontinuation of Breast Feeding with the Next Pregnancy

Most women (72.6%) felt that breast feeding should be abruptly discontinued with the pregnancy of another child. There was no difference in this widely held belief by IEF area or mother's age.

Discussion

Significant improvements have been achieved regarding the knowledge and practice of inappropriate early introduction of weaning foods. These results also compare favorably to the National Demographic and Health Survey (DHS). However, there is still substantial room for improvement in knowledge and large gaps between knowledge and practice. Current efforts encouraging exclusive breastfeeding need to continue and intensify. Promotion of exclusive breastfeeding during the first months of life should extend to TBAs and advisors. Mass media using posters and radio spots should be explored.

Special emphasis should be given to dispel myths regarding the need to abruptly discontinue breastfeeding with a subsequent pregnancy.

E. IMMUNIZATIONS

Immunization Coverage

Road to health cards were used to determine immunization coverage for children aged 12 to 23 months. All children without a Road to Health Card were assumed not to have received any immunizations. Clearly, this is a conservative assumption and will lead to an underestimate of cover. However the bias is small since only 6.0% of children had no card.

Immunization coverage is listed in Table 7. As an indicator of access to health services we found that 91.9% of children had received BCG and 95.6% had received DPT1. Compliance with the DPT and OPV schedules remained high: 91.2% received all the DPTs and 93.4% received all three OPVs. Measles coverage was 89.7%. For each one the coverage was slightly higher in the IEF area as compared to the non-IEF area ($p=0.14$, 0.035 , 0.036 for DPT, OPV and measles respectively).

Full coverage is defined as having received all three DPTs, all three OPVs and measles vaccine. Full coverage was achieved in 87.5% of children and was significantly higher in the IEF area ($p=0.029$).

A dropout is defined as a child who received DPT1 vaccine but did not receive DPT3 vaccine. Given the short space between DPT vaccines, this type of dropout indicates a serious failure of the system to maintain contact with a mother. In this survey only 4.6% of children 12-23 months who received DPT1 failed to receive DPT3.

Table 7
Immunization Coverage for Children 12-23 months
(n=259)

	IEF no.(%) (n=136)	Non-IEF no.(%) (n=123)
BCG	125 (91.9)	112 (91.1)
DPT 1	130 (95.6)	111 (90.2)
DPT 1-3	124 (91.2)	105 (85.4)
OPV 1-3	127 (93.4)	105 (85.4)
Measles	122 (89.7)	99 (80.5)
Full	119 (87.5)	95 (77.2)
Dropout	6 (4.6)	6 (5.4)

Knowledge of Measles Immunizations

Almost two-thirds (65.3%) said that measles vaccine should be given between nine and twelve months. This is an improvement over baseline where the figure was 48.6%.

Among those mothers who had taken their child for measles vaccination, 77.3% of those who believed vaccination should be before nine months actually waited until nine months or later. However, 23.9% of mothers who believed vaccination should be between nine and twelve months had their children vaccinated before nine months. Thus, overall, 22.9% of children received measles vaccination before nine months. Another 7.8% received measles vaccination after twelve months. It is somewhat comforting that most of the errors in belief and practice regarding measles vaccine are in the direction of too early vaccination, a problem that health center staff should have some control over.

Table 8
Knowledge of Measles Immunizations

Month when measles should be given	IEF no.(%) (n=300)	Non-IEF no.(%) (n=300)
Before 9 months	54 (18.0)	75 (25.0)
Nine months	144 (48.0)	131 (43.7)
10-12 months	52 (17.3)	52 (17.3)
After 12 months	0 (0.0)	1 (0.3)
Do not know	50 (16.7)	41 (13.7)

Tetanus Toxoid Vaccination (TTV)

About three-quarters (73.0%) of mothers had a TTV card. One quarter of mothers (26%) had no TTV inoculation (either on TTV card, Road to Health card, or antenatal card); 66.0% of mothers had two or more TTV inoculations. Ten percent 10% of mothers had received all five inoculations. TTV coverage was not substantially different in the non-IEF area. The proportion of women not receiving TTV did not change from baseline but the proportion at baseline receiving more than three or more inoculations (40.7% vs. 31%) and the proportion receiving five (10% vs. 0.8%) increased substantially. Most women (81.3%) knew at least one of the purposes of TTV. More than sixty percent (63.7%) knew that TTV protects both the mother and child.

Discussion

Child immunization coverage improved somewhat from baseline (64.9% vs 87.5%) and was also slightly better than in the non-IEF area. While immunization rates in all areas are very good and exceed MOH targets there is still room for improvement. Because of the long gap between DPT/OPV and measles, most attention should be directed at helping mothers to remember to bring their children in for measles vaccine. Health center staff should also be reminded to carefully check to make sure that they are not giving measles vaccine to children under nine months.

A substantial proportion of women continue to be unvaccinated with TTV. Among vaccinated women, however, the number of vaccinations per women has improved since baseline. Activities need to focus on identifying women who have never been vaccinated. TBAs and advisors may be valuable in this regard.

It is disturbing that 22.9% of children were vaccinated with measles vaccine before nine months. Health care workers need to improve their field procedures to ensure that children are not vaccinated until after nine months of age.

F. DIARRHEAL DISEASE

Prevalence of Diarrhea & Action Taken

Diarrhea (three or more consecutive loose stools in the past 2 weeks) was reported by the mothers of 35.7% of children, rising from 6.1% at 0-3 months to about 40% thereafter.

Of those children who were being exclusively breastfed before the episode of diarrhea, 81.1% were breastfed the same amount or more during the episode as compared to 69.2% for the non-IEF area ($p=0.046$). Of those children who were not exclusively breastfed before the episode of diarrhea, 67.0% were given the same amount or more fluids as usual and 67.0% were given the same amount or more food as usual. Of all the children with diarrhea, 84.1% were given some form of Oral Rehydration Therapy (ORT), the vast majority of which was through the use of ORS sachets (78.5%).

Table 9
Treatment Given for Diarrhea

	IEF no.(%) (n=107)	Non-IEF no.(%) (n=109)
<u>Treatment given</u>		
None	7 (6.5)	3 (2.8)
ORS	84 (78.5)	83 (76.1)
Sugar-salt solution	12 (11.2)	15 (13.8)
Rice Water	12 (11.2)	5 (4.6)
Fruit Juice	14 (13.1)	5 (4.6)
Pills/tablets	38 (35.5)	52 (47.7)
Other	8 (7.5)	14 (12.8)

Knowledge of Proper Action to take for Diarrhea

Women were asked what the most important things to do would be if their child had diarrhea. Only 2.3% said they didn't know. The most common answer was to take the child to the hospital or health center (82.7%). Only 10.7% said to increase fluids, however this does not necessarily contradict the high prevalence of ORT usage, since ORT was not asked about specifically.

Table 10
Most Important Action to Take for Diarrhea

<u>Action</u>	<u>No. (%)</u>
Take the child to the hospital/health center	248 (82.7)
Give the child more fluids	32 (10.7)
Give the child small, frequent feeds	94 (31.3)
Reduce fluids/food	11 (3.7)
Other	46 (15.3)
Do not know	7 (2.3)

Discussion

Use of ORT during episodes of diarrhea is very prevalent especially in IEF areas. These figures can be attributed in part to the availability of ORS in the villages. Nevertheless, this indicator does not measure whether or not the ORS was correctly prepared or administered and should be assessed at some point during the project extension. Yet anecdotal information from health center providers obtained during the final evaluation suggest that more children with diarrhea are being treated in villages and there are fewer referrals to health centers.

Feeding practices during episodes of diarrhea for older children receiving foods needs to be improved. Messages regarding feeding during diarrhea should be added to both nutrition and diarrhea education activities.

G. ACUTE RESPIRATORY INFECTION

Prevalence of ARI and action taken

Almost one-fourth (24.3%) of mothers reported that their child suffered from cough or difficulty breathing in the last two weeks. Of these, 78.1% also reported fast breathing, giving a rate of 19.0% for ARI. Of these, 68.4% reported that they took the child to the hospital or health center for treatment. This rate was slightly higher in the non-IEF area, but not statistically significant ($p=0.14$). Mother's age was not associated with the mother's decision to take the child to the hospital. Mothers who attended some school, regardless of literacy, were over 5 times as likely to take their children to hospital with an episode of ARI than mothers who had never been to school ($p=0.005$).

Discussion

Education regarding ARI is not a regular part of IEF's activities. Despite this many women reported having taken their children to a healthy facility during an ARI episode. Further investigation needs to be done to see if ARI diagnosis and treatment can be undertaken in the village.

It should be noted that the survey instrument did not appear to be very specific, diagnosing 78% of cough, colds or other respiratory infections as ARI. This appears to be a much higher prevalence that actually exists in project communities.

H. HIV/AIDS

Knowledge of AIDS & Condom Use

In recent years AIDS education in Malawi has reached almost every corner of the country. Consequently, knowledge of AIDS and condoms is nearly universal. However, specific knowledge about transmission pathways and prevention, as well as practicing of prevention measures lags significantly behind. Most women could identify a condom by sight (81.0) and this figure was the same for both areas. However, only 14.0% reported that their husband/partner had used a condom with them even once. This percentage was significantly lower in the non-IEF area ($p=0.039$). Only 1.3% of women reported condom use at least 80% of the time, and no woman said their partner used a condom always.

Condom use decreased by age of the woman, falling from 17.6% for women under age 30, to 8.0% for women 30 years of age or older. This is likely a function of literacy. Literate women were 3.9 times more likely to report condom use than illiterate women ($p<0.001$).

Table 11
Prevalence of Condom Use by Literacy & Age of Mother

<u>Literacy</u>	<u>Condom Use - No. (%)</u>
Literate (n=51)	16 (31.4%)
Illiterate (n=249)	26 (10.4%)

Odds Ratio = 3.9(95% CI: 1.8, 8.5) $p < 0.001$

Table 12
Prevalence of Condom Use by Age of Mother

<u>Age of Mother</u>	<u>Condom Use - No. (%)</u>
<20 years	4 (17.4)
20-29 years	29 (17.6)
30-39 years	9 (10.6)
40+ years	0 (0.0)

chi-square for trend test $p=0.020$

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Transmission Pathways of AIDS

It is encouraging that most women (92.3%) understood that sexual intercourse is a transmission pathway for AIDS. In addition 88.7% knew that AIDS could be transmitted by contaminated razors and needles, and 81.3% knew that AIDS could be transmitted from an infected mother to her unborn child. Less encouraging is the significant proportion of women reporting other transmission pathways for the disease (Table 13). The belief that mosquitoes can transmit AIDS is high regardless of the age of the woman. However, literate women were less likely to report that belief than illiterate women (39.2% vs. 61.4%). Literate women were less likely to report witchcraft as a cause of AIDS than illiterate women (7.8% vs 25.3%). It is worth noting that a large proportion of women (32.3%) said they did not know if witchcraft caused AIDS. For all of the other questions the proportion of women answering "don't know" was well under 20%. This uncertainty suggests that the belief in witchcraft is more prevalent than reported here.

Table 13
Transmission Pathways for AIDS Reported by Women

<u>Transmission Pathways</u>	<u>IEF Areas</u>	<u>Non-IEF Areas</u>
	<u>No. (%)</u>	<u>No. (%)</u>
Mosquitos	173 (57.7)	158 (52.7)
Sexual intercourse	277 (92.3)	289 (96.3)
Razor blades/needles	266 (88.7)	271 (90.3)
Perinatal	244 (81.3)	262 (87.3)
Witchcraft	67 (22.3)	43 (14.3)
Kissing	165 (55.0)	134 (44.7)
Sharing clothes/towels	145 (48.3)	106 (35.3)
Shaking hands	44 (14.7)	41 (13.7)

Discussion

AIDS education has accomplished a great deal in the past but much more needs to be done. Education efforts should emphasize that the disease is not transmitted through casual contact. to avoid unduly stigmatizing the disease. More effort also needs to be directed at influencing behavior change to match knowledge. While condom use rates are significantly higher in IEF areas as compared to non-IEF areas and compared to baseline, they are still low. Much improvement remains to be made. The project should consider placing more emphasis on youth, to influence the most impressionable part of the population.

I. CHILD SPACING

Desire for Additional Children & Family Planning Services

Women in this survey who were already pregnant with another child (5.3%) were not asked questions about family planning. The intention of the survey was to ask these women if they wanted another child in the next two years. However, due to a problem in translation the question asked was "Do you expect to have another child in the next two years?" This number is likely to be higher than those who want more children, as women may expect to have more children regardless of whether or not they want them.

Of those women not already pregnant, 30.7% said they expect to be pregnant in the next two years. Of these, 18.9% were using a modern method of contraception. By far, the most common method was the oral contraceptive pill, accounting for 75.7% of users. There were no differences in family planning use by area, age of woman, or literacy.

All women were asked if they would like to be using a modern family method, 68.3% responded yes. There were no differences by area, age of woman, or literacy. This questions covers a number of circumstances:

1. A woman who is currently pregnant may want to use a modern family planning method next time. In fact, 75% of currently pregnant women said they would like modern family planning, indicating their displeasure with having become pregnant too soon after the birth of the index child.
2. Even if a woman wants a child in the next two years, she may want to have proper spacing between children. Of those who said they expect to have a child in the next two years, 62.1% said they would like modern family planning.
3. Of women who are not currently using a method who would like to be, 65.4% said they would like modern family planning.
4. Those are using a method may want a better one. Of those using a method, 94.6% said they would like modern family planning.

Discussion

Use of child spacing seems to have increased from baseline, although it is difficult to tell because of the way the questions were asked. However, it is quite clear that a large proportion of women who desire child spacing services are not receiving them. Since such services are only available at the District Hospital, efforts to increase child spacing coverage should concentrate on making methods available at the health center and village level.

PVO IEF COUNTRY MALAWI FUNDING YEAR 1994

New or Expansion Project Exp Baseline or Final Survey Final (IEF)

#	INDICATOR (submit results only for indicators that reflect project interventions)	RESULTS Numerator (N) Denominator (D) Percent (P)
1	NUT: Initiation of Breastfeeding - Percent of infants/children (less than 24 months) who were breast-fed within the first eight hours after birth.	N= <u>245</u> P= <u>81.7</u> D= <u>300</u>
2	NUT: Exclusive Breastfeeding - Percent of infants under four months, who are being given only breast milk.	N= <u>16</u> P= <u>24.2</u> D= <u>66</u>
3	NUT: Introduction of Foods - Percent of infants between five and nine months, who are being given solid or semi-solid foods.	N= <u>56</u> P= <u>98.2</u> D= <u>57</u>
4	NUT: Persistence of Breastfeeding - Percent of children between 20 and 24 months, who are still breastfeeding (and being given solid/semi-solid foods).	N= <u>26</u> P= <u>76.5</u> D= <u>34</u>
5	CDD: Continued Breastfeeding - Percent of infants/children with diarrhea in the past two weeks who were given the same amount or more breast-milk.	N= <u>86</u> P= <u>81.1</u> D= <u>106</u>
6	CDD: Continued Fluids - Percent of infants/ children (less than 24 months) with diarrhea in the past two weeks who were given the same amount or more fluids other than breastmilk.	N= <u>69</u> P= <u>67.0</u> D= <u>103</u>
7	CDD: Continued Foods - Percent of infants/ children (less than 24 months) with diarrhea in the past two weeks who were given the same amount or more food.	N= <u>67</u> P= <u>67.0</u> D= <u>100</u>
8	CDD: ORT Usage - Percent of infants/children (less than 24 months) with diarrhea in the past two weeks who were treated with ORT.	N= <u>90</u> P= <u>84.1</u> D= <u>107</u>
9	Pneumonia Control: Medical Treatment - Percent of mothers who sought medical treatment for infant/child (less than 24 months) with cough and rapid, difficult breathing in the past two weeks.	N= <u>39</u> P= <u>68.4</u> D= <u>57</u>
10	EPI: Access - Percent of children 12 to 23 months who received DPT1.	N= <u>130</u> P= <u>95.6</u> D= <u>136</u>
11	EPI: Coverage - Percent of children 12 to 23 months who received OPV3.	N= <u>127</u> P= <u>93.4</u> D= <u>136</u>
12	EPI: Measles Coverage - Percent of children 12 to 23 months who received Measles vaccine.	N= <u>122</u> P= <u>89.7</u> D= <u>136</u>
13	EPI: Drop Out Rate - Percent change between DPT1 and DPT3 doses [(DPT1-DPT3) ÷ DPT1] for children 12 to 23 months.	N= <u>6</u> P= <u>4.4</u> D= <u>130</u>
14	MC: Maternal Card - Percent of mothers with a maternal card. * (ANC)	N= <u>169</u> P= <u>56.3</u> D= <u>300</u>
15	MC: Tetanus Toxoid Coverage (Card) - Percent of mothers who received two doses of tetanus toxoid vaccine (card).	N= <u>198</u> P= <u>66.0</u> D= <u>300</u>
16	MC: Ante-Natal Visits (Card) - Percent of mothers who had at least one ante-natal visit prior to the birth of the child (card). **	N= <u>169</u> P= <u>56.3</u> D= <u>300</u>
17	MC: Modern Contraceptive Usage - Percent of mothers who desire no more children in the next two years, or are not sure, who are using a modern contraceptive method.	N= <u>37</u> P= <u>18.9</u> D= <u>196</u>

COMMENTS:

* Percent of mothers w TTV card: $219/300 = 73.0\%$

** Percent of mothers reporting ANC visit $293/300 = 97.7\%$

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ID #: _____

IEF/MALAWI CHILD SURVIVAL PROJECT
KNOWLEDGE & PRACTICE QUESTIONNAIRE

All questions to be addressed to the mother with a child under 2
(less than 24 months of age).

Interview date ____/____/____ Reschedule interview ____/____/____

Interviewer name: _____

Supervisor name: _____

Village and T/A: _____

1. Name of mother: _____

Age of mother: _____ (years)

2. For youngest child under 24 months:

Name of child: _____

Birth date: ____ / ____ / ____ Months: ____

Mother's education/occupation

3. What level of school have you completed?

- 1 none
- 2 primary but I can't read
- 3 primary and I'm able to read
- 4 secondary

4. Do you have any work or method of getting money?
(Circle all answers given)

- 1 no
- 2 handicraft, sewing, etc.
- 3 harvesting, fruit picking
- 4 casual labour
- 5 selling farm products
- 6 selling food, milk
- 7 servant/household services
- 8 storekeeper
- 9 fulltime employed
- 10 other (specify: _____)

5. Who looks after [name of child] when you are away?
(Circle all answers given)
- 1 I take child with me
 - 2 child's father
 - 3 child's elder siblings
 - 4 relatives
 - 5 neighbors/friends
 - 6 worker (nanny)
 - 7 nursery school
 - 8 other (specify: _____)

Breastfeeding/Nutrition

6. Do you breastfeed [name of child] ?
- 1 yes -----> go to #8
 - 2 no
7. Have you ever breastfed [name of child] ?
- 1 yes
 - 2 no -----> go to #9
8. How long after delivery did you start breastfeeding [name of child]?
- 1 one hour
 - 2 one to eight hours
 - 3 over eight hours
 - 4 don't remember

9. Do you feed [name of child]:
- | | Yes | No | DK |
|---|-----|----|----|
| a. water or tea? | 1 | 2 | 3 |
| b. cow's milk or formula? | 1 | 2 | 3 |
| c. soft food such as phala? | 1 | 2 | 3 |
| d. fruit or fruit juice? | 1 | 2 | 3 |
| e. carrot, mango or papaya? | 1 | 2 | 3 |
| f. green leafy vegetables such as
pumpkin leaves/amaranth? | 1 | 2 | 3 |
| g. meat or fish? | 1 | 2 | 3 |
| h. peas, beans or groundnuts? | 1 | 2 | 3 |
| i. eggs or yogurt? | 1 | 2 | 3 |

10. Do you put in [name of child]'s food:
- | | Yes | No | DK |
|--|-----|----|----|
| a. green leafy vegetables such as
pumpkin leaves or amaranth? | 1 | 2 | 3 |
| b. honey or sugar? | 1 | 2 | 3 |
| c. lard or vegetable oil? | 1 | 2 | 3 |

11. Health workers say that it's very important to breastfeed the baby during the first year; what should the mother do for the first three or four days of of child's life?
(Circle all answers given)
- 1 don't know
 - 2 breastfeed the baby with colostrum
 - 3 avoid bottle feeding
 - 4 frequent sucking to increase milk production
 - 5 take care of the breast
 - 6 other (specify: _____)
12. What should the mother do in the first four months in order to keep on breastfeeding?
(Circle all answers given)
- 1 don't know
 - 2 exclusive breastfeeding
 - 3 avoid bottle feeding
 - 4 breastfeed frequently
 - 5 resume breastfeeding if stopped
 - 6 other (specify: _____)
13. Should a mother continue breastfeeding when she becomes pregnant with another child?
- 1 yes
 - 2 no
 - 3 don't know
14. When should mothers start supplementary feeding?
- 1 between four and six months
 - 2 before four months
 - 3 after six months
 - 4 don't know
15. What additional foods should be given?
(Circle all answers given)
- 1 don't know
 - 2 add lard or oil to foods
 - 3 green leafy vegetables such as pumpkin leaves or yellow fruits such as mangos
 - 4 meat, fish or eggs
 - 5 other (specify: _____)
16. What is vitamin A good for?
(Circle all answers given)
- 1 don't know
 - 2 prevent blindness/nightblindness
 - 3 prevent diarrhea
 - 4 prevent ARI
 - 5 prevent malaria
 - 6 nothing
 - 7 other (specify: _____)

17. What foods contain Vitamin A?
(Circle all answers given)
- 1 don't know
 - 2 green leafy vegetables such as pumpkin leaves/amaranth
 - 3 yellow fruits such as mangos
 - 4 meat/fish
 - 5 breast milk
 - 6 egg yolk
 - 7 none
 - 8 other (specify: _____)

DIARRHEA

18. Did [name of child] suffer from diarrhea (three or more stools in one day) in the last two weeks?
- 1 yes
 - 2 no -----> go to #25
 - 3 don't know -----> go to #25
19. When [name of child] had diarrhea did you breastfeed...
(read all answers to mother)
- 1 more than usual?
 - 2 as usual?
 - 3 less than usual?
 - 4 stopped breastfeeding?
 - 5 child not breastfed?
20. When [name of child] had diarrhea did you provide him/her with fluids other than breastmilk...
(read all answers to mother)
- 1 more than usual?
 - 2 as usual?
 - 3 less than usual?
 - 4 stopped completely?
 - 5 exclusively breastfed?
21. When [name of child] had diarrhea did you give him/her solid foods....
(read all answers to mother)
- 1 more than usual?
 - 2 as usual?
 - 3 less than usual?
 - 4 stopped completely?
 - 5 exclusively breastfed?
22. When [name of child] had diarrhea what medicine, if any, did you use?
(Circle all answers given)
- 1 none
 - 2 ORS
 - 3 sugar-salt solution
 - 4 rice water
 - 5 fruit juice
 - 6 pills/tablets
 - 7 other (specify: _____)

23. When [name of child] had diarrhea did you ask for help or medicine?
 1 yes
 2 no -----> go to # 25
24. Where did you get help or medicine when [name of child] had diarrhea?
 (Circle all answers given)
 1 District hospital
 2 health center
 3 mission hospital
 4 store
 5 VHV
 6 traditional healer
 7 TBA
 8 friends/relatives
 9 other (specify: _____)
25. What signs/symptoms would cause you to find the help or medicine for [name of child] if he/she had diarrhea?
 (Circle all answers given)
 1 don't know
 2 vomiting
 3 fever
 4 dryness of mouth, sunken eyes, decrease in urination
 5 prolonged diarrhea (2 weeks or more)
 6 blood in stool
 7 loss of appetite
 8 tiredness
 9 other (specify: _____)
26. What is the most important thing to do if [name of child] has diarrhea?
 (Circle all answers given)
 1 don't know
 2 take him/her to hospital
 3 give more fluids
 4 give little amounts of food frequently
 5 withhold fluids
 6 withhold food
 7 other (specify: _____)
27. What is the most important thing that should be done by mothers when a child has recovered from diarrhea?
 (Circle all answers given)
 1 don't know
 2 give very little food but more frequently
 3 giving more food than usual
 4 giveing high energy foods
 5 other (specify: _____)

RESPIRATORY ILLNESSES

28. Did [name of child] suffer from cough or difficulty in breathing in the past two weeks?
 1 yes
 2 no -----> go to #32

29. When [name of child] was sick did he/she have fast difficult breathing?
- 1 yes
 - 2 no -----> go to #32
 - 3 don't know -----> go to #32
30. Did you seek help when [name of child] had difficulties in breathing?
- 1 yes
 - 2 no
31. Where did you get help when [name of child] was sick?
(Circle all answers given)
- 1 district hospital
 - 2 health centre/health post/rural hospital
 - 3 mission hospital
 - 4 store
 - 5 VHV
 - 6 traditional healer
 - 7 TBA
 - 8 friends/relatives
 - 9 other (specify: _____)
32. What are the signs/symptoms of respiratory infection would cause you to take [name of child] to a health facility?
(Circle all answers given)
- 1 don't know
 - 2 fast or difficult breathing
 - 3 chest indrawing
 - 4 loss of appetite
 - 5 fever
 - 6 cough
 - 7 other (specify: _____)

AIDS/HIV/CONDOMS

33. Do you think AIDS can be transmitted by:
- | | YES | NO | DK |
|--|-----|----|----|
| a. Shaking hands with infected person | 1 | 2 | 3 |
| b. Kissing infected person | 1 | 2 | 3 |
| c. Sharing clothes/towels w/ inf person | 1 | 2 | 3 |
| d. From infected mother to child in womb | 1 | 2 | 3 |
| e. Sex with infected person | 1 | 2 | 3 |
| f. contaminated razor blades and needles | 1 | 2 | 3 |
| g. Mosquitoes | 1 | 2 | 3 |
| h. Witchcraft | 1 | 2 | 3 |
34. [show condom] What is this?
- 1 Condom
 - 2 Don't know
 - 3 Other

35. How frequently does your husband/partner use condoms with you?
- 1 Never
 - 2 Rarely (<20%)
 - 3 Sometimes (20-80%)
 - 4 Most times (>80%)
 - 5 Always

IMMUNIZATIONS/VITAMIN A

36. Has [name of child] ever received any immunizations?
- 1 yes
 - 2 no
 - 3 don't know
37. At what age should [name of child] receive measles vaccination?
- 1 months:
 - 2 don't know
38. For what reason should a pregnant mother receive TTV?
- 1 to protect both mother and child
 - 2 to protect the mother only
 - 3 to protect the child only
 - 4 don't know
39. How many times should the mother receive TTV in order for the vaccine to protect the mother and the child?
- 1 one
 - 2 two
 - 3 three or more
 - 4 none
 - 5 don't know
40. Does [name of child] have an "Under five" card?
- 1 yes (must see card)
 - 2 no -----> go to #43
 - 3 lost -----> go to #43
 - 4 don't know -----> go to #43

41.

Look at the card and record the dates of all immunizations in the spaces provided

	<u>date</u>
BCG	___ / ___ / ___
OPV:	
1st	___ / ___ / ___
2nd	___ / ___ / ___
3rd	___ / ___ / ___
DPT:	
1st	___ / ___ / ___
2nd	___ / ___ / ___
3rd	___ / ___ / ___
Measles	___ / ___ / ___

42.

Record the dates and dosage of all vitamin A capsules given to the child and mother in the space below

	<u>Date</u>	<u>Dosage</u>
Child:		
1st	___ / ___ / ___	_____ I.U.
2nd	___ / ___ / ___	_____ I.U.
3rd	___ / ___ / ___	_____ I.U.
4th	___ / ___ / ___	_____ I.U.
Mayi:		
	___ / ___ / ___	_____ I.U.

65

ANTENATAL CARE

43. When you were expecting [name of child] did you go to the antenatal clinic?

- 1 yes
- 2 no

44. Do you have an antenatal care card?

- 1 yes (must see card)
- 2 no -----> go to #46
- 3 lost -----> go to #46
- 4 don't know -----> go to #46

45.

How many times did the mother attend antenatal clinic:

- 1 one
- 2 two or three
- 3 four or more
- 4 none

46. During what month of pregnancy should a mother make her first visit to the antenatal clinic?

(probe for months)

- 1 one to three months
- 2 four to six months
- 3 seven months or later
- 4 no need to go to clinic
- 5 don't know

47. Do you have a TTV card or child's Under-5 card with information on TTV recorded?

- 1 yes (must see card)
- 2 no -----> go to #49
- 3 lost -----> go to #49
- 4 don't know -----> go to #49

48.

Look on the mother's card and record the number of TTV injections received:

- 1 one
- 2 two
- 3 three or more
- 4 none

49. Are you pregnant currently?

- 1 yes -----> go to #53
- 2 no
- 3 don't know

50. Do you expect to have another child in the next two years?
1 yes -----> go to #53
2 no
3 don't know
51. Are you using a modern contraceptive method?
1 yes
2 no -----? go to #53
52. What is the main method you are using?
(One answer only)
1 tubal ligation
2 vasectomy
3 injections (depo-provera)
4 pill
5 IUD
6 diaphragm
7 condoms
8 foaming tablets/gel
9 breastfeeding
10 NFP
11 abstinence
12 coitus interruptus
13 other (specify: _____)
53. Would you like to use a(nother) modern contraceptive method?
1 yes
2 no
3 not sure
54. How old was [name of child] when you resumed sexual intercourse with your husband/partner?
1 months: _____
2 not yet resumed sex
55. Since [name of child] was born have you had sex with anyone other than your husband?
1 yes
2 no -----> go to #58
56. How many other partners have you had?
1 Number: _____
2 don't know
57. Did any of these partners give you money or other gifts in exchange for sex?
1 yes
2 no
3 don't know
58. When [name of child] was born, who tied his/her umbilical cord?
1 mother only
2 relative
3 TBA
4 hospital staff
5 don't know
6 other (specify: _____)

Appendix 7

VITAMIN A FOR CHILD SURVIVAL

IEF PROJECT

Chikwawa District, Lower Shire Valley, Malawi

FINAL EVALUATION

FIELD INTERVIEW RESULTS

AUGUST 15 - 25, 1994

DISCUSSION GUIDE FOR COMMUNITY MEMBERS

of interviews = 11

Are you aware of the IEF Vitamin A/CS programs?

Yes = 11 No = 0

Has the VHC made any decisions or changes which you feel have been particularly important?

Yes = 8 No = 2 DK = 1

How are VHC members chosen within this community?

Community = 7 Chief = 1

HSA/VHV = 1 DK = 2

When the HSA comes to your village, does (s)he go first to see the members of the VHC or first to see the VHV?

VHC = 2 VHV = 6 DK = 3

What is the VHC's relationship with the VHV?

Good = 7 Bad = 1 DK = 3

Do the members of the VHC assist the VHV in motivating community members to seek necessary health services?

Yes = 7 No = 2 DK = 2

Does the VHV in this village receive any compensation or "incentives" for her work? Yes [] No []

Yes = 2 No = 6 DK = 3

Does the VHC help to provide or obtain money/labour/material support for the VHV?

Yes = 1 No = 7 DK = 3

What kind of support for the VHV could be provided in the future to help to motivate the VHV?

Money, helping in their garden, draw water for her, help in the household activity, provide maize

Nothing = 6

Has the VHV in this community been trained in primary eye care? Does she provide ointment for eye infections?

Yes = 7 No = 2 DK = 2

Have IEF CS/Vitamin A programs made any differences in your community?

Probe for: perceived effectiveness of CS?

Perceived as effective 8

Not perceived as effective 0

Difficult to comment 3

Probe for: any changes in the ability of communities to meet their own health needs and/or sustain CS activities?

Change observed 2

No change observed 2

Difficult to say anything 7

Probe for: any change in demand for services?

Demand increased = 2 No change observed = 9

Probe for: perceived effectiveness of the VHV?

Effective = 8 Not effective = 3

Have you received health education from your VHV/ HSA?

Yes = 3 No = 8

Has the community participated in the design/implementation/evaluation of the IEF project?

Yes = 3 No = 8

Has the community helped to provide any financial/labour/material contributions in support of project efforts?

Yes = 3 No = 8

Are any other kinds of health services needed in your community?

AIDS prevention (condom distribution), family planning, home craft, hospital, school, malaria treatment, food preservation, diarrhea treatment, food supplementation, schistosome treatment

Would you and your community be interested in basic curative services (antimalarial/antipyretics) available within your village for a small charge at the time of treatment?

Yes = 5 No = 6

Could proceeds be used to support the volunteer?

Yes = 5 NA = 6

Any other issues to discuss; Suggest ways to improve program?

Inclusion of curative services

DISCUSSION/OBSERVATION GUIDE FOR HEALTH CENTERS/MOBILE CLINICS

interviewed = 7

Is vitamin A available in Under-Fives clinics for distribution in conjunction with clinical and preventive services?

Yes = 7 No = 0

Is vitamin A available in Under-Fives clinics actually provided to all eligible children who have come for clinical and preventive services? (Exit interviews and review of u-5s' cards.)

Yes = 2 No = 1 Not observed = 3

Have there been any periods in the past year when the clinic has had no supplies of vitamin A (estimate number of weeks)?

Yes = 0 No = 7

How often are stock of vitamin A monitored? reordered?

No regular monitoring 4

Order monthly with other drugs 2

Not ordered, supplied with vaccines 1

Assess the awareness of the HC staff of IEF Vitamin A/CS programs.

Aware = 7 Not aware = 0

Does the HA have any role in supervision of the IEF HSAs?

Yes = 3 No = 2 Collaborate = 2

Have IEF CS/Vitamin A programs made any differences in your community?

Probe for: perceived effectiveness of CS?

Perceived as effective 6

Difficult to comment 1

Probe for: any changes in the ability of communities to meet their own health needs and/or sustain CS activities?

Change observed 3

No change observed 2

Difficult to say anything 2

Probe for: any change in demand for services?

Demand increased = 7 No change = 0

Probe for: perceived effectiveness of the VHV?

Effective = 6 Some are effective 1

Does the clinic staff ever use the HSAs and/or VHVs to follow-up patients (such as TB defaulters) from the Health Center?

Yes = 1 Occasionally = 1 No = 4

DISCUSSION GUIDE FOR HEALTH COMMITTEE MEMBERS

interviewed 10

How many meetings has the VHC had within the last six months?

None = 2 One = 2
Two = 5 Three = 1

How many members are on the VHC?

Five = 1 Nine = 1 Ten = 8

Proportion of Women on VHC?

20% = 2 30% = 3 40% = 2
50% = 1 60% = 1 80% = 1

When was the last routine meeting of the VHC?

1 day ago = 1 2 wks ago = 1 4wks ago = 2
2 mns ago = 2 4 mns ago = 2 Don't meet = 2

How many members attended the last meeting?

80% = 4 30% = 1 Don't remember = 3

What issues does the committee address during its discussions?

Environmental sanitation, water supply, AIDS prevention, child spacing, shortage of drug and lack of health facility

Two VHC have done nothing

What methods/activities does the VHC use in doing its work?

Households visit and health education

Has the VHC made any decisions or changes which you feel have been particularly important?

Improved sanitation: latrine construction and water protection

Three VHC made no significant change

How are VHC members chosen within this community?

By community = 8
By the chief = 1
By HSA/VHV = 1

Is your VHV a member of the VHC? Yes[7] No[3]

Does s/he come to the meetings? Yes[7] No[1] NA[2]

Does the HSA attend the VHC meetings? Yes[4] No[2] NA[2]

When the HSA comes to your village, does (s)he go first to see the members of the VHC or first to see the VHV?

Chief = 2 VHC = 2 VHV = 6

What is the VHC's relationship with the VHV?

Good = 9 Bad = 1

Does the VHV report her findings regarding coverage (or other indicators) to the VHC on a regular basis?

Yes = 4 No = 6

Do the members of the VHC assist the VHV in motivating community members to seek necessary health services?

Yes = 5 No = 5

If yes, specify How.

Health education through household visit

Does the VHV in this village receive any compensation or "incentives" for her work? Yes [] No []

Yes = 6 No = 4

Does the VHC help to provide or obtain money/labour/material support for the VHV?

Yes = 2 No = 8

What kind of support for the VHV could be provided in the future to help to motivate the VHV?

Money contribution = 1

Assist in activities = 1

None = 8

Does she provide ointment for eye infections?

Yes = 6 No = 3 Dk = 1

Have IEF CS/Vitamin A programs made any differences in your community?

Probe for: perceived effectiveness of CS?

Perceived as effective = 9

Not perceived as effective = 1

Probe for: any changes in the ability of communities to meet their own health needs and/or sustain CS activities?

Change observed = 8

No change observed = 2

Probe for: any change in demand for services?

Demand increased = 6

No change observed = 4

Probe for: perceived effectiveness of the VHV?

All are effective = 8

Some are effective = 1

Not effective = 1

Has the community participated (through the VHC or other mechanism) in the design/implementation/evaluation of the IEF project?

Yes = 2 No = 8

Has the community helped to provide any financial/labour/material contributions in support of project efforts?

Yes = 3 No = 7

Are any other kinds of health services needed in your community?

Sanitation, Family planning, AIDS, Drugs, Hospital/clinic, water, school, malaria treatment and first aid

Would you and your community be interested in basic curative services (antimalarial/antipyretics) available within your village for a small charge at the time of treatment?

Yes = 4 No = 6

Could proceeds be used to support the volunteer?

Yes = 3 No = 1 NA = 6

Any other issues to discuss; Suggest ways to improve program?

Transport for labouring women

DISCUSSION GUIDE FOR VILLAGE HEALTH VOLUNTEERS

interviewed = 9

What activities do you engage in as a volunteer?

Vitamin A distribution, ORS distribution, eye treatment,
registration of families, assist in under 5 clinic, health
education

Time spent on voluntary work = range 3 - 15 hours/week,
majority 3-4 hours/week

Are you satisfied with your job? Yes = 6 No = 3

How long will you continue as a volunteer?

Until the end of the project = 3
For life/for long time = 6

How often are you visited by you HSA for supervision

1-2 times/ week

Do you participate in the meetings of your VHC?

Yes = 4 No = 5

Are you a member of VHC?	Yes = 3	No = 6
Does the HSA attend the VHC meetings?	Yes = 3	No = 6
Do you attend under fives' clinics?	Yes = 6	No = 3

When the HSA comes to your village, does (s)he go first to see you
or first to see the VHC members or other community leaders?

VHC = 4 VHV = 5

How many meetings has the VHC had within the last six months?

None = 3 One = 3
Two = 2 DK = 1

How many members are on the VHC?

Ten = 4 Seven = 1 DK = 4

What is the proportion of women on the VHC?

10% = 1 20% = 1 40% = 2
60% = 1 DK = 4

When was the last routine meeting of the VHC ?

2 wks = 1 4 wks = 2 12 wks = 2
DK = 1 Doesn't meet = 3

How many members attended the last meeting?

80% = 3 70% = 1 DK = 2

What issues does the committee address during its discussions?

Sanitation, need for health services, under-five clinic,
protection of water source, digging latrine and family
planning

What methods/activities does the VHC use in doing its work?

Households visiting

Has the VHC made any decisions or changes which you feel have been particularly important?

Yes = 6 No = 3

How are VHC members chosen within this community?

By community = 6 Dk = 3

Are you a member of the VHC?	Yes = 2	No = 7
Do you go to the meetings?	Yes = 3	No = 6
Does the HSA attend the VHC meetings?	Yes = 0	No = 9

What is your relationship with the VHC?

Good = 7 No communication = 2

Do you report your findings regarding coverage (or other indicators) to the VHC on a regular basis?

Yes = 5 No = 4

Do the members of the VHC assist you in motivating community members to seek necessary health services?

Yes = 7 No = 2

Do you receive any compensation or "incentives" for your work?

Yes = 8 No = 1

If yes, would you continue without incentives?

Yes = 6 No = 2

Does the VHC help to provide or obtain money/labour/material support for the VHV?

Yes = 2 No = 7

If yes, specify: labour

Has the community participated (through the VHC or other mechanism) in the design/implementation/evaluation of the IEF project?

Yes = 4 No = 5

Has the community helped to provide any financial/labour/material contributions in support of project efforts?

Yes = 3 No = 6

What kind of support could be provided in the future to help to motivate you to continue your work?

Improve drug supply, money, supply uniform, continue giving soap, supply oil, supply shoes and supply stationery

Have you been trained in primary eye care? Yes = 8 No = 1

Have IEF CS/Vitamin A programs made any differences in your community?

Yes = 6 No = 3

Probe for: any changes in the ability of communities to meet their own health needs and/or sustain CS activities?

Yes = 5 No = 4

Probe for: any increased demand for services?

Yes = 8 No = 1

Are any other kinds of health services needed in your community?

AIDS prevention activity, Family planning, nutrition clinic,
malaria treatment and curative services

Would you and your community be interested in basic curative
services (antimalarial/antipyretics) available within your village
for a small charge at the time of treatment?

Yes = 7 No = 2

Have you had adequate supplies of vitamin A?	Yes = 7	No = 2
ORS?	Yes = 2	No = 7
Condoms?	Yes = 1	No = 8
Tetracycline?	Yes = 0	No = 9

Any other issues you would like to discuss?

Hand bags, road construction is needed, want HSA to be based
in the villages, provide VHV's with more drugs, want health
workers at the health post, more soap, boreholes, schools

DISCUSSION GUIDE FOR VILLAGE LEADERS

interview = 7

Are you aware of the IEF Vitamin A/CS programs?

All yes

Has the VHC made any decisions or changes which you feel have been particularly important?

Yes = 6 No = 1

How are VHC members chosen within this community?

By community 7 (all)

When the HSA comes to your village, does (s)he go first to see the members of the VHC or first to see the VHV?

Village headman

What is the VHC's relationship with the VHV?

Have good relationship

Do the members of the VHC assist the VHV in motivating community members to seek necessary health services?

Yes = 4 No = 3

Does the VHV in this village receive any compensation or "incentives" for her work?

Yes = 0 No = 7

Does the VHC help to provide or obtain money/labour/material support for the VHV?

Yes = 0 No = 7

What kind of support for the VHV could be provided in the future to help to motivate the VHV?

Yes: helping in his/her garden
building/repairing his/her house
helping on his/her problem
visiting him/her when sick

Nothing: the community is poor (said by 4 leaders in 1 interview)

Does the VHV provide ointment for eye infections?

Yes = 2 No = 4 Dk = 1

Have IEF CS/Vitamin A programs made any differences in your community?

Probe for: perceived effectiveness of CS?

Perceived as effective = 7

Not perceived as effective = 0

Probe for: any changes in the ability of communities to meet their own health needs and/or sustain CS activities?

Change observed = 6

No change observed = 1

Probe for: any change in demand for services?

Demand increased = 7

No change observed = 0

Probe for: perceived effectiveness of the VHV?

Effective = 7

Not effective = 0

Has the community participated (through the VHC or other mechanism) in the design/implementation/evaluation of the IEF project?

Yes = 1 No = 6

Has the community helped to provide any financial/labour/material contributions in support of project efforts?

Yes = 1 No = 6

Are any other kinds of health services needed in your community?

Family planning, Eye treatment, AIDS prevention, health post

Would you and your community be interested in basic curative services (antimalarial/antipyretics) available within your village for a small charge at the time of treatment?

Yes = 7 No = 0

Could proceeds be used to support the volunteer?

Yes = 7 No = 0

DISCUSSION GUIDE FOR HEALTH SURVEILLANCE ASSISTANTS

interviewed = 11

Assessment of issues concerning the role of HSAs after the end of the next project:

Will you and other HSAs accept transfer to the MOH at the end of the next three year project?

Yes = 7 No = 2 Not sure/reluctant = 2

Will HSAs be willing to take on a smaller catchment area and use a push-bike instead of the motor bike?

Yes = 7 No = 0 NA = 2

What are your concerns and ideas about sustaining project activities at the end of the next three years?

sustaining incentive for VHVs = 5

training & supervision = 3

no concern = 3

Are you satisfied with the amount and quality of your training?

Amount: Enough = 3 Short = 8

Quality: Good = 11 Bad = 0

Are you satisfied with the amount and quality of your supervision?

Amount: Satisfactory = 10 No answer = 1

Quality: Good = 9 Bad = 1 No answer = 1

Who supervises you? Are you also supervised by the HA?

IEF = 5

IEF & MOH = 4

IEF & occasionally MOH = 2

How often (specify number of times per month)?

1 - 2 times per week

Can we see your (specify whether seen, completeness, etc):

Commodity Distribution Form? { good }

VHV Supervisory Checklist? { good }

Health Education Report? { good }

General comment : overworked